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OF TASMANIA

**Thesis Title:**

**Patient utilisation of private health insurance in public hospitals: influencing factors and impacts of use.**

**By: Jason (Yang) Cheng**

**Student ID: 141289**

**Australian Institute of Health Service Management**

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**Date Submitted:**

**09/02/2015**

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## **Statement regarding published work contained in thesis**

At the time of submission, no part of this thesis has been published in any form.

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Jason (Yang) Cheng

Date: 09/02/2015

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## Abstract

This research, which consists of a number of sub-projects, aims to understand a range of issues relating to private health insurance (PHI) utilisation in a New South Wales (NSW) public hospital. There has been controversy around the Australian Federal and State Government funding arrangements in relation to healthcare services in Australia, and added complexity is seen with the increased uptake of PHI in Australia. The controversy generally revolves around which body (State or Federal Government, PHI company, patient) should fund the ever-increasing cost of healthcare in Australia, as well as the decision from a patient's perspective when electing which body will fund their care when visiting public hospitals. This thesis focuses on the latter part of the problem; the complex and controversial nature of this topic motivated the researcher to gain a deeper understanding of the decision-making process of patients when it comes to choosing to use PHI.

While much has been written about the interaction between PHI and Medicare systems, and the healthcare funding arrangement in Australia in general, very little research has been conducted into the factors that influence the utilisation of PHI in public hospitals. This shapes the relevance and importance of the study, because there are several reasons as to why the utilisation of PHI in public hospitals is important. Firstly, using PHI in public hospitals provides patients with a financial choice. Also, it serves as an incremental source of income for public hospitals. In this way, patients (and PHI funds) provide a way for public hospitals to cover their capacity costs (infrastructure, medical technology). This, in turn, could make public healthcare more sustainable in the future.

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In this research, the rationale behind why patients choose to use or not to use PHI in public hospitals is surveyed. The results of 336 out of 450 respondents (indicating a 74.67% response rate) identified several main reasons as to why patients chose to use their PHI for the public hospital admission: the possibility of admission to a single room; the ability to choose their own preferred doctor; the opportunity to help the hospital and the community; and the occasion to avail of some of the other benefits that come with using PHI. The results have also identified several main reasons as to why patients have not chosen to use their PHI: they did not know they could use their PHI for their public hospital stay; they were worried that their health insurance premiums would increase if they used their PHI; and fear of out-of-pocket expenses. In the second part of this research thesis, a financial model was developed to aid the analysis of the cost and revenue impact of encouraging patients to use PHI. It has been found that during the 2011/12 financial year at Canterbury Hospital, a revenue of approximately \$3 million (AUD) was raised, with a cost of \$519,176.14. The return on investment (ROI) was 5.59 (i.e. the net revenue was 5.59 times that of the cost or 559%), indicating an excellent return versus cost. These results reaffirm that the efforts that public hospitals have devoted to encouraging patients to use PHI is worthwhile.

These results surrounding PHI encouragement-strategies could potentially be used to develop possible methods for how PHI capture-and-conversion rates could be improved in other NSW public hospitals. However, while some have argued that public hospitals should not actively encourage patients to use their PHI given the multiple pressures bearing down on the Australian healthcare system, as well as the fact that the pitfalls of a mainly government-funded universal healthcare systems have been well documented, it is difficult to justify that the taxpayer-funded free Medicare public healthcare system would always be a sustainable sole-funding



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system in the future. Instead, allowing PHI to play a more active role in supporting a system under pressure, and allowing patients to have a choice, may assist in increasing the longevity and sustainability of the nation's public healthcare system.

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## 1. Introduction

During the past few decades in Australia, healthcare services have, traditionally, been financed principally by State and Federal Government funding through taxpayers' money. Rapid development in healthcare technology, an ageing population and growing labour costs are all contributing factors to the increasing cost of healthcare services (Howe, 2000). In Australia, increased healthcare costs are burdening the free public healthcare system (Australian Institute of Health and Welfare, 2005). In fact, the so-called "free" public healthcare system is not entirely free; it may be perceived as being free by service users because they do not have to pay at the point of contact, but given that the majority of the population pays a Medicare levy, those service users do actually incur the cost of the public healthcare system.

As the public becomes better informed about and therefore more sophisticated consumers of healthcare services, their expectations of the level of service they receive grow. This expectation gradually increases along with an increase in living standards and life expectancy, and the resulting increase in demand for better quality becomes difficult to satisfy when the government alone bears the provision costs. There is an increasing need to diversify the source of funding when it comes to meeting the demand for healthcare services. This is a problem faced by many countries in the world, both in developed and developing (WHO, 2010). Gadiel and Sammut (2012) have estimated that for the state of New South Wales (NSW), if the health expenditure is not appropriately controlled in 20 years, it is likely to consume the entirety of the State Government's budget. Establishment of private hospitals, allowing doctors to practice privately, the introduction of private health insurance (PHI) and co-payments, and enabling healthcare providers to recoup some of their

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costs are methods that could alleviate the pressure of relying on the taxpayer's money as a sole funding source. The purchase of PHI is gradually being accepted by the general public as a co-existing health funding system parallel to the Medicare Benefit Scheme (MBS). The "State of our public hospitals" report released by the Australian Department of Health and Ageing in June 2010 outlined that in 2007–08, Australia spent an estimated \$103 billion on all healthcare services (the latest year for which this figure is available). More than a quarter (\$30.8 billion) was spent on public hospital services, and just over 7% (\$7.7 billion) was spent on private hospitals. The remaining costs were spent on primary health care such as community and public health, Pharmaceutical Benefit Scheme, Medicare, administration, research, dental services and other health goods and services.

When discussing about the topic of PHI, it is first essential to understand what the term "insurance" actually mean. The Oxford Dictionary of English (2010, p. 907) defines insurance as: "A practice or arrangement by which a company or government agency provides a guarantee of compensation for specified loss, damage, illness, or death in return for payment of a premium. For example, many new loan borrowers take out insurance against unemployment or sickness to reduce their financial risk, should they lose their jobs or fall ill. It should be noted that the definition emphasises that the purpose of insurance is to provide compensation and to act as a form of risk minimiser for a specified cost. An alternative way of looking at the purpose of insurance is that it decreases uncertainty for the insured party.

According to the Australian government's Private Health Insurance Ombudsman (PHIO) (2012), there are two types of PHI – "hospital policy" cover for a patient going into hospital, or "general policy" (sometimes known as "ancillary" or "extras") cover for secondary treatment (e.g. dental, physiotherapy) (PHIO, 2012). Most health funds

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offer combined policies that provide a packaged cover for both hospital- and general-treatment services, or alternatively it is possible to purchase separate hospital and general treatment policies to match one's needs.

Usually, for people purchasing cover for the first time, or upgrading a plan, it is necessary to serve a waiting period before they are able to make a claim on their insurance policy. During the waiting period, the insured party will either not receive any benefits for certain treatments, or will receive lower benefits for a period of time. Hospital cover policies help cover the cost of in-hospital treatment by the patient's doctor and hospital costs such as accommodation and theatre fees. Generally, any medical services listed under the MBS can be covered on some form of private hospital insurance. Some services which are not listed on the MBS, such as elective cosmetic surgery or laser eye surgery, are only covered by private hospital insurance to a limited extent or not at all. (PHIO, 2012)

PHI funds in Australia generally offer several different policies across various coverage categories, combined with different levels of excess or co-payment. The coverage categories are varied in terms of the monthly premium payable and the coverage offered. Usually, lower the premium, the more limited the coverage.

An excess is usually the amount that the insured party agrees to pay towards the cost of hospital treatment, in exchange for lower premiums. One may be required to pay an excess every time they go to hospital, or only the first time, depending on the terms of the PHI policy. According to the PHIO (2012), a co-payment is where one agrees to pay a set amount for each day they are in hospital, in exchange for lower premiums – for example, an insured patient could agree to pay the first \$50 per day

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they are in hospital. Usually, the excess is what a patient has to pay for a set number of days, and once this set amount is reached, the patient does not need to pay any more.

Many health funds offer packaged policies that provide cover for both hospital and general treatment services. Some funds have pre-packaged policies, while others allow patients to mix and match hospital and general treatment options. For example, one may be able to select a basic hospital cover and a comprehensive general treatment policy to create a combined package.

An important aspect to note regarding PHI is that in NSW, Medicare does not cover ambulance costs. A person (patient) who is treated by paramedics is responsible for paying any fees associated with their treatment and/or transport, regardless of whether or not they were the individual who requested the ambulance; however, some ambulance services are provided free of charge to people in receipt of a benefit entitlement – depending on the patient's situation, they could be eligible to subsidised transport. Most of the emergency departments in NSW hospitals belong inside public hospitals. In order to arrange ambulance cover, a patient needs to be registered with a private health fund. An ambulance levy is usually included as part of a registered health fund's basic hospital cover. Some funds also offer “ambulance only” insurance. It can be noted that one of the reasons as to why some patients choose to purchase PHI may be because they would like to be covered for ambulance transport.

Over the past few decades in Australia, several policy initiatives have been employed by the Federal Government to encourage patients to take up PHI. Policy makers assumed that when more people took up PHI, they would use the insurance when attending public hospitals, thus relieving the pressure on public health funding

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(Segal, 2004). Recent policy developments in Australia saw that the uptake of PHI had increased, and the percentage of patients with PHI had been maintained at relatively high levels (Yong & Palangkaraya, 2005). It has been noted that generally a significant portion of patients who visited the public hospitals in Australia hold PHI (Sullivan, Redpath, & O'Donnell, 2002). As indicated by the study conducted by Sullivan, Redpath and O'Donnell (2002), the portion of patients using their PHI in public hospitals is significantly lower than the percentage of patients actually holding PHI cover; however, there appears to be a scarcity of similar studies conducted in addition to this, and there also appears to be limited sample and research scope in the aforementioned study. This means that the results from these studies are inconclusive or difficult to provide detailed insight into the very topic. These are some of the factors that have motivated the current research.

This thesis aims to outline a research proposal for investigating issues affecting the election of PHI in a NSW public hospital from both a decision-theory and economic-benefits point of view. The first part of this thesis is the literature review, which forms an integral part of this research proposal. It starts with an examination of the background of the Australian healthcare system, describing the funding elements and the key relationships between Medicare and PHI, as well as outlining any relevant political and policy developments surrounding these elements found in the existing literature. It will be a structured examination of the topic of healthcare funding and Australian PHI policy development to date. This introduction chapter aims to set a scene and establish the background for understanding the context of the research. Followed by that, there is a review of the financial decision-making process by people in purchasing PHI and using PHI in a public hospital. The next chapter (Theories: Choices and decisions) focuses on literature concerning the impact of using PHI in public hospitals on both the individual patient and on the

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hospital system. During the literature review, a number of inconsistencies will be examined. While some scholars have indicated their view of why certain decision theories should be used in examining patient motivations, others have argued that humans are irrational and are therefore not always capable of making rational decisions. Another part of the literature review will examine some scholars' views of why patients should or should not use their PHI in a public hospital; others have attempted to point their arguments more towards the validity of funding in public healthcare.

The literature review will also describe any previous studies on the economic impact of an individual's choice not to use PHI, and the documented processes for encouraging people to use PHI in public hospitals. This part aims to determine if other researchers found any economic rationale for encouraging PHI utilisation through empirical studies. Throughout this part of the research thesis, the list of relevant articles will be critically reviewed and evaluated in relation to any gaps, biases, and errors in logic or judgement. The literature review will outline any gaps in the existing literature, as well as any potential points for improvement upon these studies. The current study aims to bridge some of these knowledge and scope gaps, and will lead on to the subject of potential new studies.

The rationale behind how this literature review is structured is that it will first provide relevant background information pertaining to the topic, as well as a historical development of it in order to structurally inform scholars. Introducing the wide range of background literature that has been studied, and exploring the financial decision choices that patients make, provides useful insight into the reasons as to why other scholars have adopted their chosen study perspectives. The subsequent literature review identified in the "Financial decision making and PHI – a review" intends to

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zoom in and examine the economic impact of patients' financial choices around whether or not to use PHI in the public hospital. This theme is central to informing scholars on the current understanding of the actual impact of patients' choices, and how they relate to public hospital finance and funding. Based on conventional views, the actions to encourage more patients to use PHI in public hospitals are advantageous and financially rewarding to hospitals, and a review of any empirical studies highlight how certain strategies are more effective than others would enhance the understanding of this topic area. Finally, any gaps and shortfalls that can be identified in these past studies will justify why another study is required in the attempt to bridge these knowledge gaps.

The sections that follow will describe the new study, undertaken in accordance with the gaps and errors identified during the literature review. This chapter begins to talk about the research questions and the importance and contribution of the research to the extant literature. The research questions are: What are the factors that influence a patient's utilisation of PHI in a public hospital? What are the impacts of using PHI?

The Method chapter will then focus on the research method; it is intended that this chapter will be prescriptive in making the methodology clear and understandable. This chapter will describe the research material, procedures and protocols which forms part of the research plan, during which time and resource issues associated with the study will be discussed. It is important to understand what time and resource requirements are required, or what contingencies should be put in place, in order to ensure that the research is conducted within a realistic timeframe and with the allocated resources. After that, the relevant ethical considerations will be examined. Finally, the paper will conclude with a summary of the key points discussed in the



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paper's research proposal, and the potential applications of the research findings will be examined.

It should be noted that the scope of this thesis is not to devise schemes aimed at attracting private patients (i.e. those who intended to go to private hospitals) to go to public hospitals. Instead, this research is concerned with patients who have entered the public hospital system who have PHI and their decision on whether or not to use PHI.

Furthermore, it is important to note that the concept of revenue in this thesis can also be defined partly as the cost recovered by public hospitals from the PHI funds of those patients who decided to use their PHI cover to fund their public-hospital admission. It needs to be noted that the term revenue in this instance is different from the ordinary market definition where revenue is referred to as making money. The researcher is not intending for public hospitals to be perceived as conducting profit-driven exercise; rather that, under the existing health funding arrangement in Australia, and given the pressure on its healthcare system, the focus is on the need for public hospitals to recover costs – that is, funding public healthcare through available alternative sources, such as PHI, as well as using current government funds. A key point needs to be noted that if public hospitals continue to fail to recover these costs, then the public healthcare system imminently faces increasing funding pressures.

### **1.1. Research Site Selection**

The proposed study will be conducted at one of the hospitals located within Sydney Local Health District (SLHD, see Appendix 1) – one of the 18 Local Health Districts

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(LHD) in NSW, Australia (as a result of the 2010 national health reform, Area Health Services in NSW were transformed into smaller LHDs).

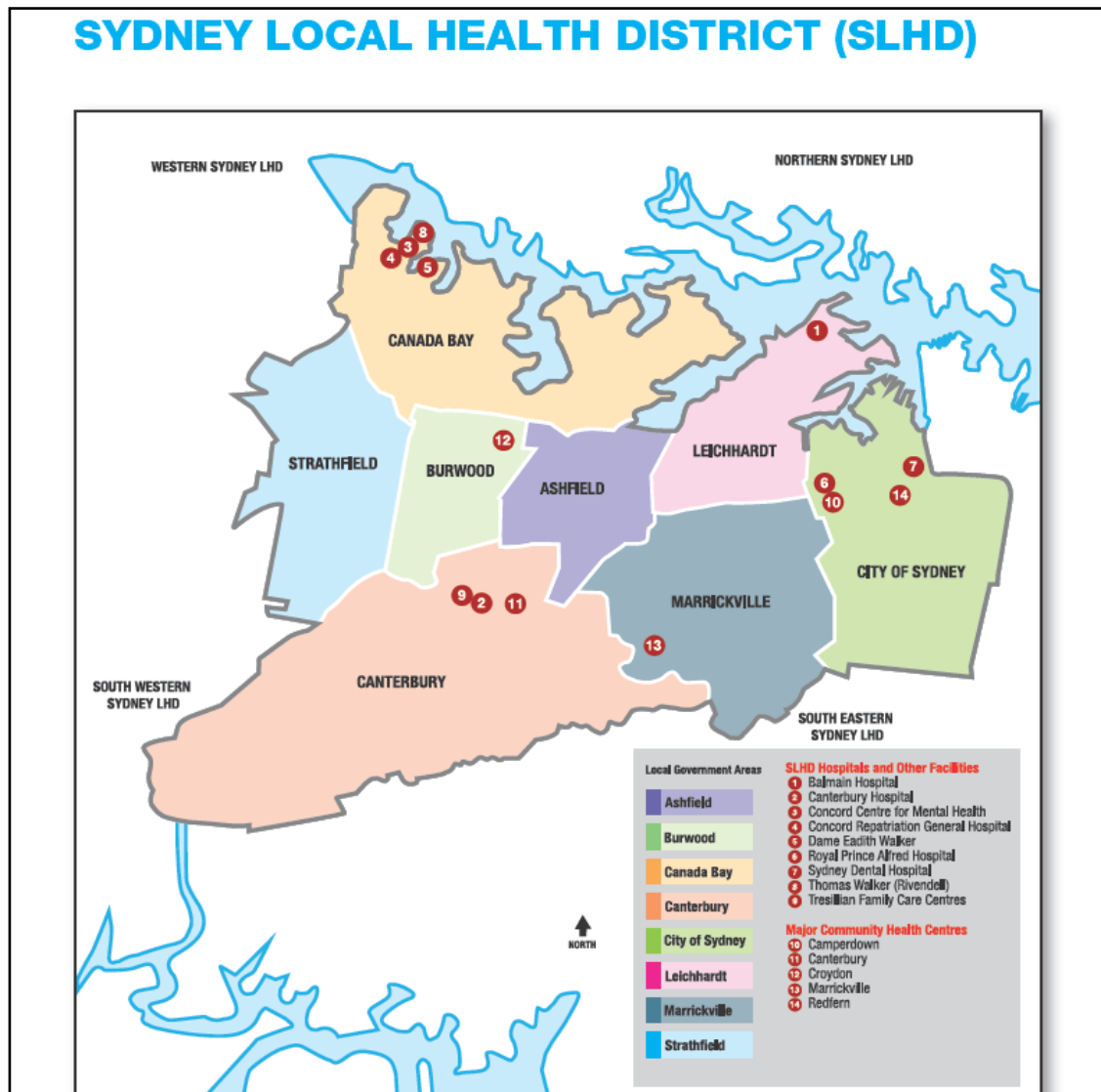
The SLHD is located in the centre and inner west of Sydney, and comprises eight Local Government Areas (LGAs), namely the City of Sydney (part), Leichhardt, Marrickville, Canterbury, Canada Bay, Ashfield, Burwood and Strathfield. Covering 126 square kilometres and with a population density of 4,210 residents per square kilometre (ABS 2006), the SLHD is responsible for providing care to more than 530,000 people. It has an ethnically diverse community, with 51.5% of the population speaking a language other than English within their own homes. The major languages in the community aside from English are Mandarin, Cantonese, Arabic and Greek.

The district population is ageing, with the number of residents aged over 70 projected to increase by 29% over the next decade. Each year, almost 8,500 babies are born to mothers residing in SLHD, with 6,852 of these deliveries occurring in the two maternity units in SLHD (SLHD, 2012).

A significant Aboriginal population resides in the SLHD, especially around the Redfern/Waterloo area, in the City of Sydney and in Marrickville. Aboriginal people are widely recognised as having poorer health and poorer access to appropriate health services.

The SLHD is characterised by socio-economic diversity, with pockets of both extreme advantage and extreme disadvantage. “The LGAs with the highest proportion of the population being Centrelink customers include Canterbury, Marrickville and Ashfield. Mean taxable income is lowest in the Canterbury LGA, which has a higher index of disadvantage than the rest of the State” (SLHD, 2012, p.17).

Hospital data indicates that SLHD residents over the age of 65 years used 50% of all acute hospital bed days for SLHD residents in 2009-10 (NSW Health FLOWInfo V 10.0 2010).



By 2021, the local SLHD population is expected to reach 642,000. Significant planned urban developments include: the new Green Square Development in Zetland and Beaconsfield in the City of Sydney; urban consolidation along the Parramatta Road corridor; and new developments in Rhodes, Breakfast Point, the former Carlton United Brewery site and Redfern/Waterloo.

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The research covered in this dissertation is conducted at Canterbury Hospital, SLHD. This is due to the researcher's employment at the hospital, and the associated advantages in accessing information, resources and support. The researcher has had extensive experience working in the field of public-hospital corporate and financial services management. PHI and public hospital funding was a key element of the researcher's job role. The specialist knowledge that the researcher possess in the topic area has assisted the researcher to gain a good understanding of the problems, challenges and opportunities in the area. The hospital has an established finance department overlooking the management of PHI revenue. There is information and existing databases on the trend of PHI utilisation and patient financial-election conversion rates. The researcher's familiarity with the hospital and access to expert knowledge on the topic area presents an advantage in conducting the specific study at this health facility.

Canterbury Hospital is a Major Metropolitan Group B1 hospital, providing a range of district-level services for the local community at mainly role delineation level-4 and a palliative care unit with a catchment covering all the Inner West. There are 4 private hospitals located within an approximate five-kilometre radius of Canterbury Hospital. There is a need to discuss the private hospitals surrounding Canterbury Hospital. This is because given that there is free choice for patients to choose the way how they wish to fund their hospital admission, there is relationship between PHI, public hospital and private hospitals. Some could argue that private hospitals are a substitute for public hospitals, others would suggest that private hospitals would provide better quality of care, higher standards and superior services compared to public hospitals. However, in this thesis the key is the choice that patients decide on whether or not to be a private patient in a public hospital, given that options exist for them to be admitted to a private hospital.

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- **The Sydney private hospital**

The hospital is equipped to perform many types of surgical procedures, including:

- Orthopaedic
- Ear, nose and throat
- Ophthalmology
- Plastic surgery
- Gynaecology
- General surgery (including lap banding)
- Urology and endoscopy

- **Wesley Hospital, Ashfield**

Wesley Hospital, Ashfield, is a 38-bed facility offering an extensive range of in-patient and day-patient programs for people experiencing mental health problems. The hospital is in Ashfield, in inner-west Sydney.

- **Alwyn Rehabilitation Hospital**

Alwyn Rehabilitation Hospital is an independently owned and operated 26 bed private hospital, dedicated completely to physical rehabilitation.

- **Kingsgrove Day Hospital**

Kingsgrove Day Hospital provides private medical services, hair loss treatments, and follicular unit transplantation.

Above is a brief description of the type of services being provided by private hospitals to the Canterbury locality and the surrounding areas. While it is recognised that there may be some overlap of services between these private hospitals and

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Canterbury Public Hospital, patients who hold PHI and choose to utilise a private hospital's service are not bound by geographical constraint. That is, they are free to use any private hospital's service regardless of where they live. However, generally speaking, patients are encouraged to visit their nearest public hospital to seek medical attention.

It should be noted that clinical services provision between public and private hospitals are generally complementary to each other rather than in direct competition with each other. Private hospitals provide more choice to people who hold PHI, and who are willing and can afford to access private medical treatment. Public hospitals deal with the vast majority of the population who choose to come in as public Medicare patients. The section below examines the type of services being offered by Canterbury Hospital from a specialist service's perspective.

Canterbury Hospital has been designed to offer quality care in modern, purpose-built facilities. The hospital provides clinical services in the following areas:

- Emergency medicine
- Cardiology and cardiac rehabilitation
- High dependency unit (HDU)
- Surgical sub-specialties including general, Ear Nose and Throat(ENT), orthopaedics, urology and gynaecology
- Medical sub-specialties including general medicine and respiratory with other sub-specialties on consultation
- Maternity, special care nursery and paediatric
- Aged care, rehabilitation & Palliative care

- 
- Dental
  - Drug health
  - Imaging – Computed Tomography (CT), ultrasound, and general radiography

The Canterbury LGA is located in Sydney's south-west, approximately 17 kilometres from the Sydney General Post Office (GPO). Canterbury City includes the suburbs of Ashbury (part), Belfield (part), Belmore, Beverley Hills (part), Campsie, Canterbury, Clemton Park, Croydon Park (part), Earlwood, Hurlstone Park (part), Kingsgrove (part), Lakemba, Narwee (part), Punchbowl (part), Riverwood (part), Roselands and Wiley Park, as shown in Figure 1 below. While Canterbury City is predominantly a residential area, there are also significant commercial and industrial areas. The City of Canterbury is well served by both state transit and private bus services, as well as by the Sydney Trains network. There are train stations at Belmore, Campsie, Canterbury, Hurlstone Park, Lakemba, Narwee, Punchbowl and Wiley Park.

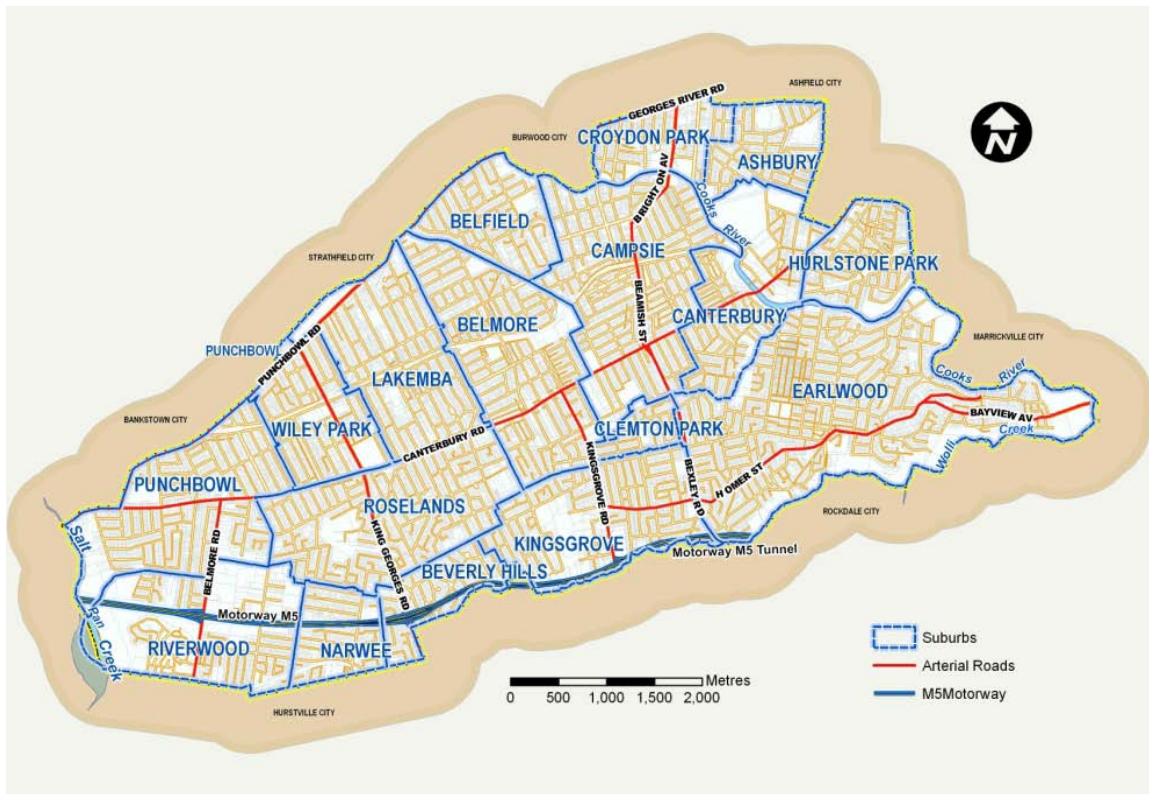
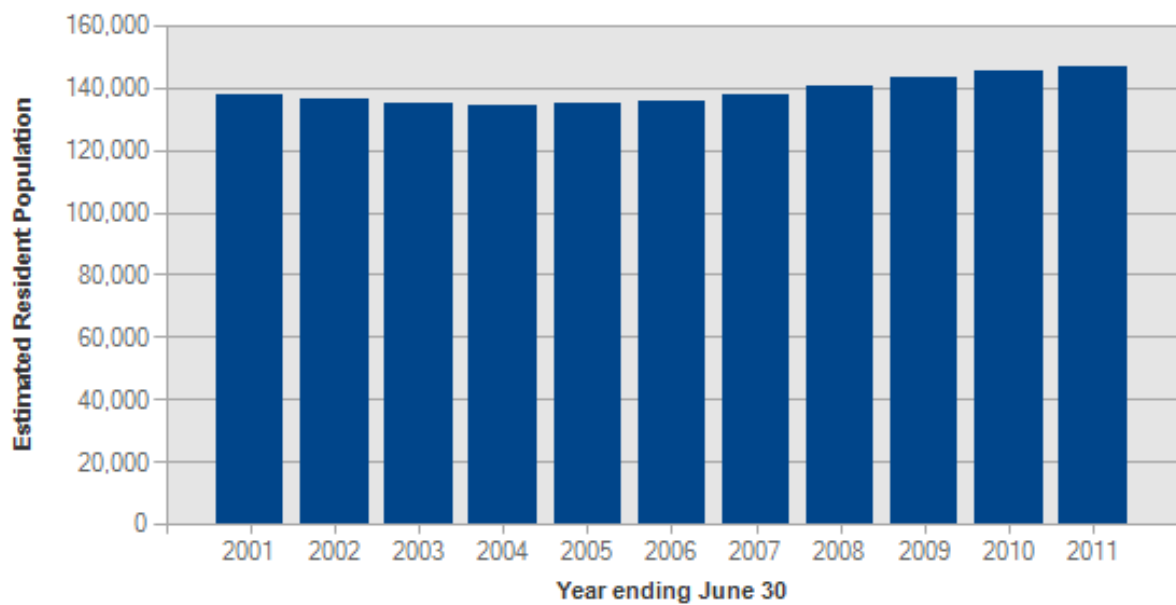


Figure 1. Canterbury Local Government Authority, Canterbury City Council (2010)

#### Estimated Resident Population, Canterbury City Council



Source: Australian Bureau of Statistics, Cat. No. 3218.0 - Regional Population Growth, Australia, 2009

Figure 2. Australian Bureau of Statistics (2009)



## Socio-Economic Indexes for Areas (SEIFA) by Local Government Area

### SEIFA by small areas

SEIFA index of disadvantage	
Local Government Areas in the Sydney Statistical Division	
(Ranked from greatest to least disadvantaged)	2006 SEIFA index of disadvantage
Fairfield (C)	876.1
Auburn (A)	922.1
Canterbury (C)	927.1
Bankstown (C)	944.7
Campbelltown (C)	954.5
Canada Bay (A)	1076.5
Waverley (A)	1082.2
Leichhardt (A)	1082.9
Sutherland Shire (A)	1083.8
Warringah (A)	1084.1
Hunter's Hill (A)	1099.4
Willoughby (C)	1099.6
Hornsby (A)	1099.8
Pittwater (A)	1106.9
Manly (A)	1107.9
North Sydney (A)	1114.1
Baulkham Hills (A)	1116.5
Lane Cove (A)	1116.9
Woollahra (A)	1121.7
Mosman (A)	1130.1
Ku-ring-gai (A)	1143.3

Source: Australian Bureau of Statistics, Socio-Economic Indexes for Areas (SEIFA), 2006.

\* Report Data Extracted from SEIFA 2006 Complete Report Table

Figure 3. Australian Bureau of Statistics, Australia (2010)

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Household income is one of the most important indicators of socio-economic status. Analysis of individual income levels in Canterbury City in 2006 compared to the Sydney Statistical Division (Sydney SD) shows that there was a smaller proportion of people earning a “high” income (\$1,000 per week or more) but a larger proportion earning a “low” income (less than \$400 per week).

The Canterbury LGA is experiencing population growth and such growth is estimated to increase, Figure 2. Overall, 11.8% of the population were classed as earning a high income, and 47.4% a low income, compared with 21.7% and 38.1%, respectively, for the Sydney SD. This lower status is based solely on the income comparison obtained from the 2006 national census data. It is visible from Figure 4 that over 15% of the population aged over 15-years earn a weekly income of \$150 to \$249 a week. The income figures indicate that Canterbury LGA is considered to have a lower socio-economic status compared to Sydney statistical region’s average.

It is worth noting that the socio-economic demographics of a case hospital and its patients may also have some correlation to the level of PHI utilisation. This is measured in Figure 3 through the Socio-Economic Indexes for Areas (SEIFA), SEIFA is developed by the ABS that ranks areas in Australia according to relative socio-economic advantage and disadvantage. The indexes are based on information from the five-yearly Census. In the case of Canterbury Hospital, the area serviced by this hospital has a relatively lower average income compared to the State’s average income; the research would examine the utilisation of PHI as well as the economic benefits to the hospital. Due to this lower-than-average socio-economic status, it is considered that understanding the motivations of using PHI in Canterbury Hospital could provide important insights into PHI utilisation in public hospitals in a wider

context. The findings may be more readily generalised to other public hospitals located in suburbs that are of higher socio-economic status than that of Canterbury LGA.



Figure 4. Canterbury Local Government Authority income, Canterbury City Council (2010)

More than half of Canterbury's population spoke a language other than English at home, indicating a high level of cultural diversity in the Canterbury LGA, as shown in Figure 5.

Language top 10 non-English languages ranked for 2006 (persons aged 5 years and over)	Canterbury						
	2006			2001			Change 2001 to 2006
	number	%	Sydney Statistical Division %	number	%	Sydney Statistical Division %	
Greek	684	12.2	2.0	734	12.9	2.1	-49
Arabic	506	9.0	3.9	499	8.8	3.6	8
Cantonese	331	5.9	3.0	317	5.6	2.9	14
Mandarin	284	5.1	2.4	301	5.3	1.6	-17
Italian	257	4.6	1.7	251	4.4	2.0	5
Portuguese	201	3.6	0.3	199	3.5	0.3	2
Vietnamese	164	2.9	1.8	181	3.2	1.7	-17
Spanish	118	2.1	1.1	72	1.3	1.1	46
Korean	104	1.9	0.9	118	2.1	0.7	-13
Filipino (Tagalog)	70	1.2	1.1	80	1.4	1.0	-9
Speak English Only	1,922	34.2	63.9	1,813	31.9	66.5	110
Non-English total	3,361	59.7	29.3	3,419	60.1	27.6	-58
Not Stated	342	6.1	6.7	457	8.0	5.9	-115
Total	5,625	100.0	100.0	5,688	100.0	100.0	-64

Figure 5. Canterbury Local Government Authority demographics, Canterbury City Council (2010)

Understanding the relevant hospital information and surrounding area's demographic profile is useful when it comes to the preparation of the study. It allows the researcher to develop research instruments that are relevant and compatible to the target population. It also provides possible background explanations on certain phenomena observed during the study. It should also be noted that this information allows academics and hospitals that wish to use this thesis's findings/results to apply in their local environment with some guiding parameters. In other words, the findings and results of this study should be applied with the consideration of the target LGA's demographics and local environment.

There is particular relevance in conducting an empirical study on a public hospital site due to a number of reasons. Firstly, conducting this field study onsite is important for gaining insights about utilisation of PHI in public hospitals, as well as understanding any knowledge gaps to help guide future research. Secondly, experience-based study enables an understanding of the potential in applying any

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useful research results and findings to other public hospitals. This learning can also be extended and could be applied to other types of healthcare facilities.

Furthermore, understanding patients' decision-making process and what factors influence their decisions via the empirical study could expand the knowledge for healthcare providers from various aspects. By increasing the knowledge around the financial impact of patients using PHI in public hospitals, health managers are able to make more informed decisions about cost and resource utilisation. There could be a number of possible applications for the findings of the study.

- Understand how to conduct a research and writing a research paper
- Learn from other scholars about the impact of PHI policies on health services
- Enhance the general knowledge about patients' decision-making process regarding whether or not to use PHI for their healthcare
- The Local Health District (LHD) could use the findings from this thesis to develop relevant training and education material for staff and managers to improve PHI capture rate

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## 2. Background: Health Funding & PHI

There is cost involved in providing health care, irrespective of whether the population benefiting it through the user pay system or universal free health care. When considering cost and expenditure, there is the need to discuss how it is funded and what limits, parameters and constraints surround the funding of such cost. This chapter looks into the funding implications of health, with a particular focus on hospital care.

“Opportunity cost”, referred to by Colander (2010), is the benefit that one might have gained from choosing the next-best alternative. Colander (2010) described how the term is widely used in two distinct ways, both in the academic and non-academic literatures. From a practical perspective, to obtain the benefit of something, one must forgo something else; opportunity cost is the value of that next best alternative, and it is considered to be a cost because by choosing one thing, one is precluding an alternative.

In the context of the hospital setting, when resources are scarce, the cost of allocating resource to project A instead of project B is known as the opportunity cost. For example, when a hospital needs to allocate its fixed annual budget to treat more renal patients for the year, then the opportunity cost would be that it is unable to treat more patients in other areas, such as heart disease patients, for example.

Opportunity cost is a relevant concept in the context of health and resource management because health resources are often fixed and limited. When resources are allocated, there is a shift of resources between alternatives. In health policy development, there is cost involved in shifting resources between alternatives.

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Additional resources for one purpose have to come from somewhere, so the reduction of resources in another area would result in some form of opportunity cost.

As opportunity cost is an important aspect of health service funding, its relationship with PHI will be discussed. In this chapter a range of literature will be examined in order to understand the health funding concept, as well as PHI policy-development issues in Australia.

## **2.1. Funding Of Medicare: An Evaluation**

This section provides a background of the discussion on PHI through a brief evaluation of funding for the universal health care system – Medicare. It is essential to understand how Medicare and PHI co-existed and the historical developments behind them.

The national health insurance of Australia – Medicare – was first introduced by the Labour government in 1984, under Prime Minister Bob Hawke. This is a tax-funded scheme aimed at providing universal and affordable public healthcare to the people of Australia. People also have the option to access healthcare through a private healthcare arrangement that exists in parallel to Medicare. In fact, prior to the introduction of Medicare, the vast majority of the population held some sort of cover through either a PHI fund or self-funded medical cover. The financing of Medicare occurs mainly through the federal government's tax revenue, that is, the Medicare levy – based on the taxable income of an individual (Connelly & Doessel, 2000). In general, Medicare covers the cost of patients being treated as a public patient in a public or a private hospital (in which sometimes there are arrangements made with governments to care for public patients). In addition, it allows private patients to be treated in public hospitals with some government assistance, and provides some coverage for the cost of private medical services (under the MBS), the

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Pharmaceutical Benefits Scheme (PBS), as well as the cost of limited dental care (eligible healthcare cardholders etc).

When a patient is admitted to a public hospital, they may generally choose to be admitted either as a public patient – funded by Medicare – or as a private patient – PHI-funded or self-funded. Public patients are entitled to free treatment and services that are essential to the treatment (e.g. meal, accommodation and medication). Private patients in a public hospital are charged a fee; this cost is lower than the fee charged at a private hospital and is normally met by another funding body, e.g. a PHI fund. If a patient chooses to be admitted to a private hospital they are generally charged a higher rate than they would be at a public hospital. This cost, in most instances, is wholly or partly (depending on coverage) covered by the PHI fund that the patient is enrolled in. In the case of private patients who are eligible for Medicare (generally Australian Citizens, Permanent Residents and Humanitarian-Visa holders), the doctor's fee generally attracts Medicare benefits (Department of Health and Aged Care, 2000). For private patients, Medicare benefits payable for the services provided is at 75% of the MBS fee. The remaining 25% is usually covered by the health fund for private patients.

Health services that are provided to patients by a private doctor either inside or outside a hospital are wholly or partially reimbursed by Medicare. There are also types of health services that are not covered by Medicare, e.g. dental care to patients not holding a healthcare card, non-rebatable MRI scans, plastic surgeries, workers' compensation claims, and motor accident insurance claims, etc.

Prescription medications are covered under a separate scheme (the PBS). In general, the PBS subsidises about 75% of all prescription drugs dispensed in Australia.



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Since the establishment of Medicare first in 1984, there have been many changes to the scheme. The Medicare agreement in the early 2000s went through some dramatic changes; many of the changes are still affecting the delivery of Medicare services today, for example the changes of Medicare levy payment and the changes of eligibility of covered treatment types etc.

Rapid increases in healthcare expenditure over recent decades is a national budgetary issue that is commonly faced by developed countries (Australian Institute of Health and Welfare, 2005). In addition to the increases in expenditure, consumer expectation of quality and timely provision of healthcare also continues to increase.

The health expenditure data from the Australian Institute of Health and Welfare (2012) highlights the increasing healthcare costs. According to Health Expenditure Australia 2011–2012, healthcare expenditure in Australia in 2011–12 was \$140.2 billion (or \$5,952 per person), up in real terms (after adjustment for inflation) from \$82.9 billion in 2001–02 and \$132.6 billion in 2010–11. This means that health expenditure as a proportion of Gross Domestic Product (GDP) stands at 9.5% for 2011–12, up from 8.4% in 2001–02. The current OECD (Organisation for Economic Co-operation and Development) country average health expenditure to GDP ratio is 9.0%.

At the same time, Australians' OOP spending on healthcare grew, in real terms, to 6.2% in 2003–04 – up from 5.0% the previous year. Real growth in expenditure by individuals between 1993–94 and 2003–04 was 5.4% per year, 0.8 percentage points above the real growth in healthcare expenditure of 4.6% per year over the period (Duckett, 2005b).

Introduction of Medicare in 1984 was not aimed at eradicating PHI from Australia. In fact PHI is an important component of healthcare financing in Australia. According to

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a report released by Australian Institute of Health and Welfare (2008) in 2006-07 PHI funded 7.8% of total recurrent healthcare expenditure. In a recent report released by the Private Health Insurance Administration Council (PHIAC), 44.5% of the Australian population hold private hospital cover (PHIAC, 2010).

PHI in Australia has some distinctive features:

- It provides coverage for services (either partially or wholly) uncovered by Medicare such as ancillary covers like: dental, alternative therapy and optical care.
- PHI provides double coverage (either partially or wholly) for the costs of health services already covered by Medicare such as hospital accommodation and prostheses costs.
- PHI is prohibited to provide cover for outpatient based services for the fee difference between the doctor's fee and MBS bulk bill rate (85% of schedule fee).

When admitted to a public hospital, public patients are assigned a doctor (can be a senior or junior doctor depending on clinical priority or whether the doctor is available). For insured people, PHI provides additional benefits to public entitlements such as increased choice of doctors and hospitals, shorter waiting times and perceived better quality at private hospitals (Paolucci et al., 2008). Private patients in these circumstances are given the choice of choosing their own doctor.

## **2.2. Development Of Private Health Insurance**

During the 1970s and 1980s various Australian governments made changes to the funding of health care in Australia through the introduction of Medibank in 1974,

Medibank Private in 1976 and then Medicare in 1985. The intent of these strategies were to develop a health system that is universal in coverage, equitable in distribution of costs, and administratively simple to manage. It was recognised then that private and public funding both played important roles in financing health care in Australia. Following on from the discussion of Medicare, this section discusses the historical and political context of the development of PHI.

A review of literature has identified a number of issues that may have caused the Australian Federal Government to consider changes to its PHI policies in the mid-1990s.

It became apparent in the early 1990s that Australia's healthcare expenditure was increasing at a faster than expected rate (AIHW, 1996). At the same time the co-funding of healthcare expenditure by means of voluntary health insurance was at a steady decline, according to figures from PHIAC, coverage fell from 41% in 1992 to an all-time low of 30% in 1998.

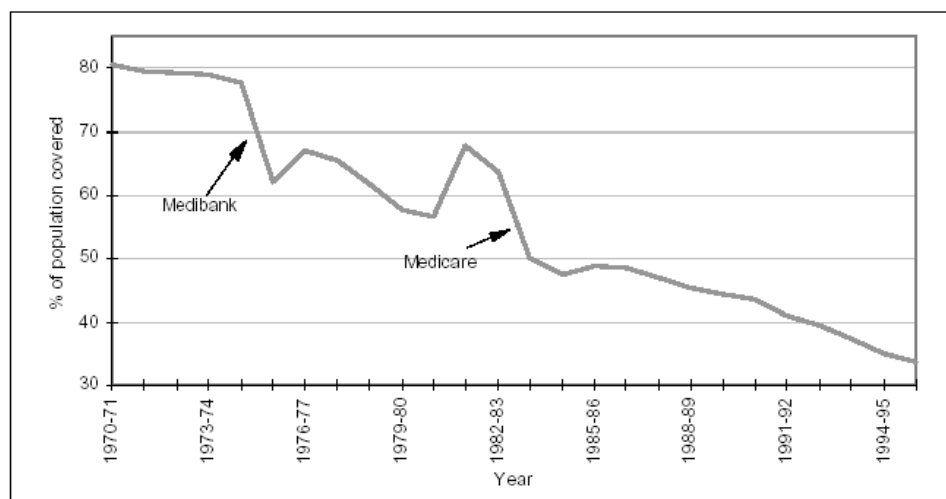


Figure 6. Private Health Insurance Administration Council, Percentage Of Population Covered With Private Health Insurance By Year (1996)

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In 1993, Mr Russell Schneider, Chief Executive Officer of the Voluntary Health Insurance Association of Australia (VHIAA), says that if something is not done soon to get more people into private insurance, then the industry could collapse. The total burden would then fall on Medicare, which is already not coping (Harrigan, 1993).

In 1994, Federal Minister for Health, Senator Graham Richardson says that changes are needed to Australia's health insurance sector, where proportions of Australians with private healthcare dropped from 60% 10 years ago to 40% today (Ragg, 1994). Mr Richardson says that he is keen to "encourage people to take out private health insurance" (Harrigan, 1993).

Following the introduction of Medicare, the Labour government from 1984 to 1996 provided some stability to health policy and pursued a passive policy of allowing health insurance to continue to decline (Duckett, 2003). The reduction in uptake of PHI represents that more Australians were reliant on Medicare. The Minister for Health, Senator Graham Richardson, was keen to find alternative ways to increase funding for the nation's healthcare system. This complex political and economic climate laid the foundations for the policy development of PHI during that period.

A 1997 study aimed at examining the uptake of PHI in Australia revealed that PHI was caught in a downward spiral caused by the adverse selection identified in the Australian Government Industrial Commission report (1997). It appeared that rising premiums triggered by increasing costs induced low-risk members to withdraw, as they could no longer see the benefit of retaining their private insurance covers. Without the cross-subsidy of high-cost/high-risk members, premiums were forced to rise again, which further increased premiums, which induced further departures. The report argued that this continuing spiral is the major cause of the reduction in the rate of the population's uptake of PHI cover.

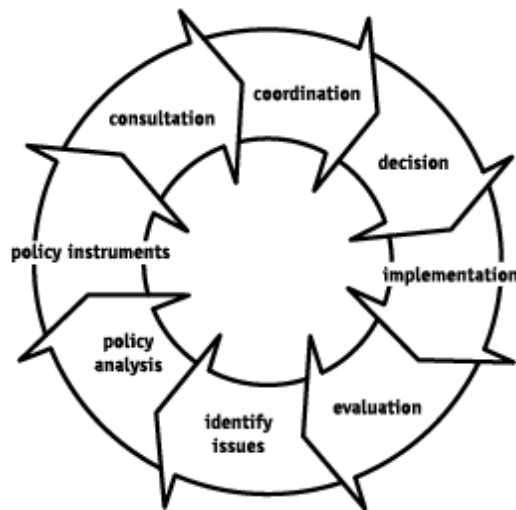


Figure 7. An Australian policy cycle model (Bridgman & Davis, 2004)

Bridgman and Davis (2004) suggested that a policy cycle could be used to understand and thus structure policy development, bringing a system and a rhythm to a world that might otherwise appear chaotic and disorderly. The cycle structures the policy process into manageable units of analysis. The PHI-policy development and healthcare reform in the 1990s was a complex process; the development of these policy instruments somewhat loosely mirror the model highlighted above. It was after iterative discussions, analysis and consultations that, eventually, a total of three major policies in the implementation stage were applied. In chronological order, they were:

- (1) The PHI incentives scheme, introduced in 1997, which imposes a tax levy on high-income owners without PHI.
- (2) A 30% premium rebate introduced in 1999 aimed to attract more people to take up PHI with a monetary incentive.
- (3) Lifetime Health Cover introduced in 2000, permits a limited form of client risk rating by age, encouraging mid- to high-income owners to purchase PHI.

Accompanying the implementation of these policies, the government produced series of education and public awareness programs to promote PHI to the general population (Manners, 2003). After the introduction of the policy on a 30% premium rebate, the average number of people who have taken out PHIs has increased steadily over the past decade. It appears that although the implementation of these policies was not entirely a uniformly coordinated process, many subsequent services initiated changes and programs to accommodate the new policies.

It appears that after the introduction of the aforementioned policy changes, the rate of PHI uptake increases dramatically (from 34% in 1996 to 45% in 2000); however, this figure begins to drop in 2001 and continues to fall gradually in recent years.

	1995		2001	
	Singles	Families	Singles	Families
NSW	21.2	44.2	33.7	52.5
VIC	25.4	42.9	35.6	52.8
QLD	23.2	44.2	31.9	50.8
SA	30.7	43.2	36.0	53.1
WA	26.5	44.1	43.7	57.3
TAS	26.7	44.3	33.6	52.7
NT	18.9	35.8	31.3	54.3
ACT	23.9	44.2	45.1	62.0

Figure 8. Percent Population with private health insurance by states/territories,

Private Health Insurance Administration Council (2002)

It can be noted that according to the ABS 2011-2012 National Health Survey (NHS), the proportion of people covered by PHI differs by age group. The highest level of PHI coverage in 2011–12 was among the 55–64-years age group (around 67.5%), compared to 47.2% among the 18–24-years age group.

Levels of PHI membership also differed across a range of other demographic characteristics, particularly in relation to labour-force status and levels of socio-

economic disadvantage. Socioeconomic disadvantage refers to people's access to material and social resources as well as their ability to participate in society. People living in areas with relatively high levels of socio-economic disadvantage had the lowest levels of PHI in Australia (33.4%), while people living in areas of low disadvantage had the highest levels (79.4%). This is illustrated in the graph below.

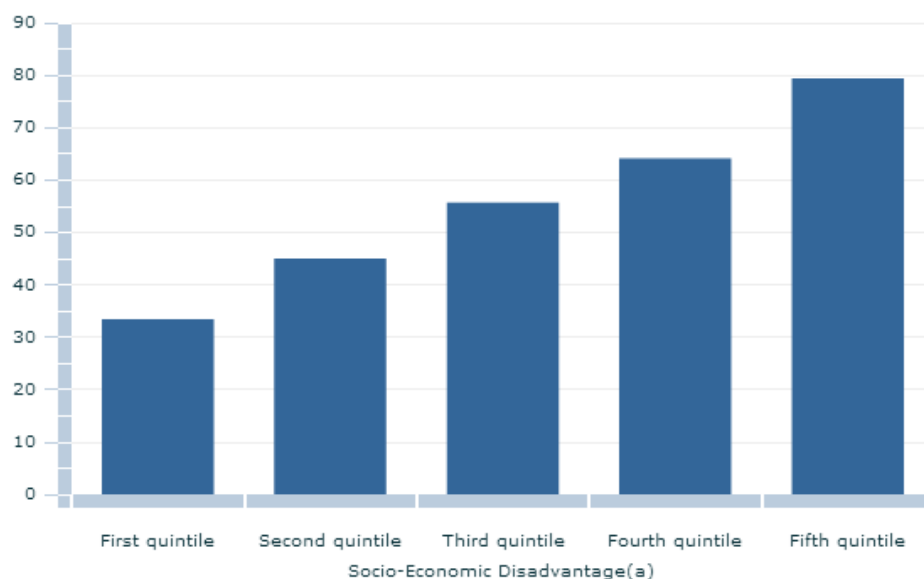


Figure 9. Proportion of all persons aged 18 years & over with PHI, Australian Bureau of Statistics (2014)

In 2011–12 there were 9.7 million adult Australians with PHI (57.1% of all people aged 18-years and over). This was an increase from 2007–08, when 52.7% of adult Australians had PHI cover.

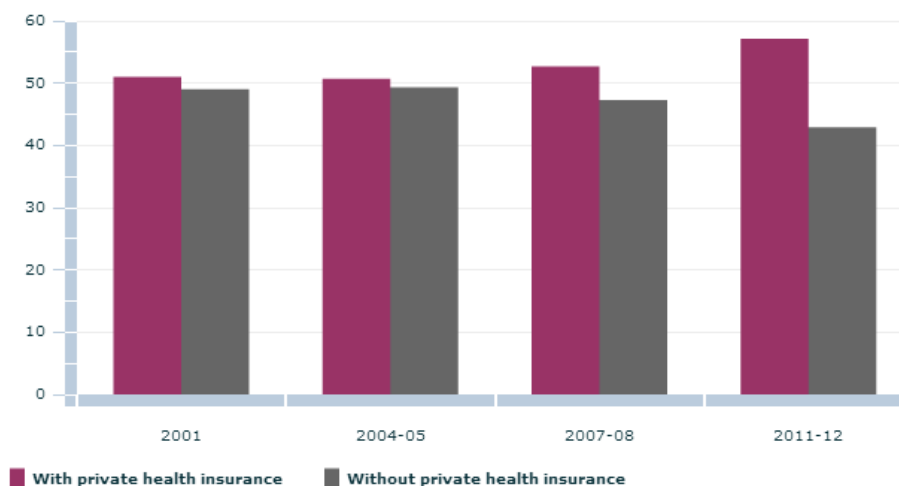


Figure 10. All persons aged 18-years & over: Proportion with & without private health insurance cover, 2001 to 2011–12, Australian Bureau of Statistics (2014)

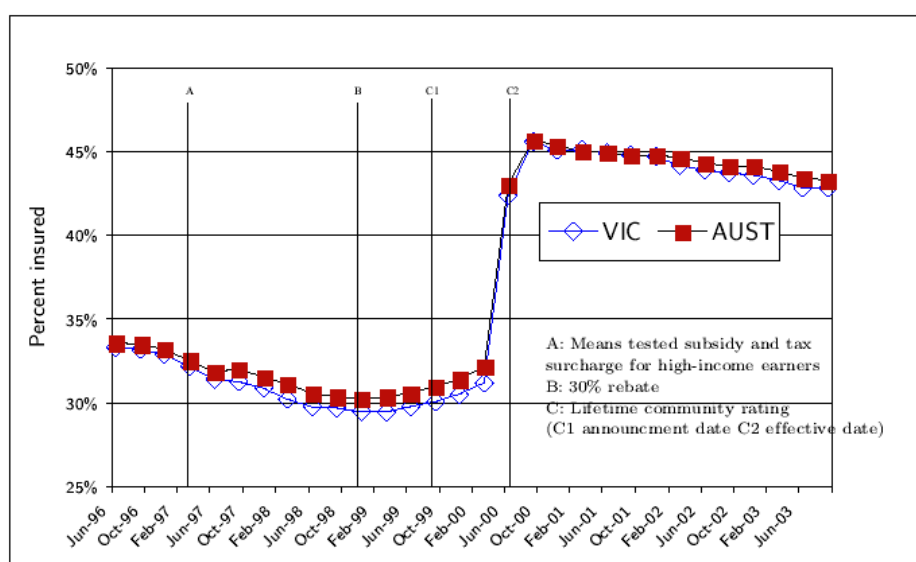


Figure 11. Percentage of the population with PHI: Victoria & Australia. Private Health Insurance Administration Council (2003)

More recent development of PHI policies occurred in 2007. The “Broad Health Cover” provisions enable a wide range of services to be covered by PHI, including preventative care, alternative therapies, domestic nursing, allied healthcare and chemotherapy. However these provisions do not cover GP services or aged care costs under PHI (Private Health Insurance Act, 2007). Premium rebate and lifetime



healthcare provisions had also undergone some changes. For example, the increase of income threshold of liability for the Medicare levy surcharge (MLS) (which started at \$50,000 per annum for singles (pre-2008) and increased to \$77,000 per annum (2010-2011), and \$100,000 per annum for families (pre-2008) to \$154,000 per annum (2010-2011)) could mean that, for taxation purposes, people earning below these thresholds may be less inclined to take out PHI.

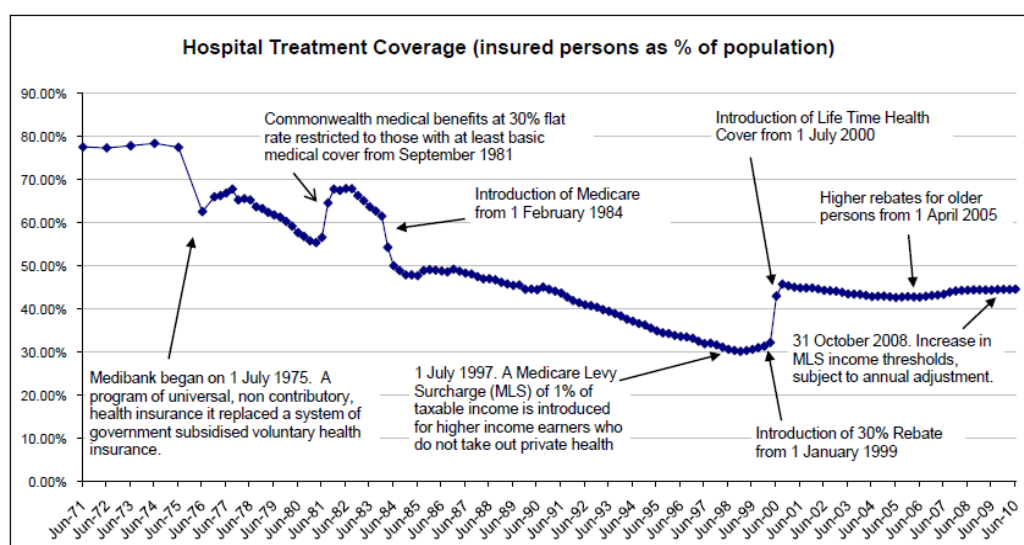


Figure 12. PHI policy development and PHI coverage. Private Health Insurance Administration Council (2010)

According to the ABS data (2011), approximately 81% of the population living within the Canterbury LGA earn a combined family income of less than \$154,000 per annum. It is possible to assume that there could be a large proportion of the families not willing to take out PHI for taxation purposes, as the Medicare levy would largely not apply to them. It may, therefore, be possible to argue that choice and decision about purchasing PHI cover is determined by at least one factor: income. The literature review chapter that follows aims to understand the theories around people's choices and the decision-making process that occurs in relation to the use of PHI.

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### **3. Literature Review: Theories On Choices & Decisions**

To understand the reasons of whether or not people choose to use their PHI in a public hospital, it is important to understand the motivations behind their decisions and how they are influenced by these motivations. People make choices based many factors, scholars have written extensively about what these factors are. This chapter looks into some of these factors closely and attempt to understand the level of influence they have on patient's decision on PHI utilisation in a public hospital. A number of literature and theories are examined within this chapter to guide the discussion on how people choose between choices and make decisions.

#### **3.1. Major Theories**

##### **Utility Theory**

The term “utility” has many different meanings in various different contexts. In the context of economics, utility is generally referred to by a numerical measure in terms of satisfaction and a measure of goal achievement. Given this measure, one may speak meaningfully of increasing or decreasing utility, and thereby explain economic behaviour in terms of attempts to increase one's utility. In the context of PHI utilisation, different patients have different view of what utility or value actually means.

There is the possibility that some patients may think that by using PHI, the mere fact that it helps the local hospital equates good utility/value. Even though he/she may not be the direct beneficiary of the decision if such decision helps the hospital as a whole rather than bringing benefits to themselves as individuals. However, on the other hand, some other patients may not see this as of great utility; as they would like to consider avoiding any perceived or potential financial risks. They would like to

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be a public patient and use Medicare as it is an experience they are familiar with. This decision is also bringing maximum utility to them as they have mitigated an unknown financial risk of using PHI. Moreover, some other patients may think that the maximum utility is achieved when they can be allocated into a single room or have a doctor of their choice as they can see the direct benefits to them.

In the context of healthcare, it is relevant to note that the concept of utility is an important consideration in the understanding of PHI, particularly when it comes to the patients' choices around taking out/using their existing PHI cover. However, it is also important to recognise that as the perspective of utility varies between each individual, utility has different perceived values depending on the individual's individual circumstances and frame of reference. Therefore, utility theory, although useful in its economic concepts, its application is somewhat limited, because an individual's decision-making process largely depends on the individual's perspective rather than fitting closely with some sort of objective utility evaluation.

## **Decision Theory**

Manner (2009) suggests that decision theory in economics and psychology is concerned with identifying the values, uncertainties and other issues relevant in a given decision, its rationality, and the resulting optimal decision. Manner (2009) also indicated that this concept is closely related to the field of game theory where agents with conflicting interests whose decisions usually affect each other. Decision theory generally assumes an ideal decision-maker who is fully informed, able to compute with perfect accuracy, and fully rational.

There are generally two categories of thought in decision theory, the normative approach and the descriptive approach. The normative approach is a theory about

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how decisions should be made in order to be rational. The descriptive theory is focused on how people actually make decision that is how decisions are actually made to maximise the value of decision outcomes for an individual (Dilworth, 2010). The decision theory is a foundation for guiding the search of tools, methodologies and software to help people make better decisions. In modern corporations, the application of prescriptive decision theory is evident in the utilisation of decision support systems. For example, in most decision support systems the decision making process is usually based on weighing the potential value for each decision outcome.

It is not uncommon to find examples of ambiguities and even confusions between normative and descriptive interpretations of one and the same theory in decision-theoretical literature. It can be conceded, however, that it is more difficult in decision science than in many other disciplines to draw a sharp line between normative and descriptive interpretations. This is probably because the decision making process is sometimes complex and depends on the individual's preference of approach or a mixed use of both approaches.

Putting the distinction issues aside, there are several flaws with the normative and prescriptive decision theories. To start with, decision theory assumes people are rational; this assumption is not based on accurate fact but an ideal. When people are making decisions based on what they identify as the best decision, the best decision does not always mean that they are achieving the best value or most optimal utility; instead, the best decision is based on what a person views to be most important or most relevant, it may not necessarily be the objective fact. In addition to this, people are rarely always rational when making decisions, and yet many would deny the fact that they are irrational (Böhm & Wibecke, 2008). Furthermore, it should be noted that

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when it comes to decision making, people may use different reference points to judge what optimal utility means to them (O'Neill, 2010), this aspect of utility theory has been discussed in the literature review chapter above. For example, the fact that a photocopier can print 60 pages per minute may be seen as having high level of utility to a university lecturer who needs to print large volumes of paper. However, to a student who just needs to print some documents sparingly, there tends to be less need for such a high printing speed. It is therefore possible to argue that the high cost attached to purchasing such a high-performance printing device may reduce the perceived utility. What one could get as the extra performance cannot be justified by the cheaper purchase cost (in this case, it is likely that faster print speed is of relatively lower utility/value to a student than to a lecturer who needs to print large volumes quickly).

Next, decision theory generally assumes that the decision-making process involves a decision maker who is fully informed. This assumption is heavily flawed, due to the fact that rarely do decision makers seek the full information regarding the matter they are deciding on unless they are intimately involved in the making or the production of the matter they are deciding on. For example, from one sense it is difficult to argue that a person with no legal background who wants to engage in a legal dispute with someone else in relation to land title rights is fully informed of his/her legal rights, unless the person is fully aware of and understands the legislation around land title rights, planning rules and insurance matters.

Furthermore, decision theory assumes that people are able to compute with perfect accuracy in evaluating outcomes and the utility of an option. This argument bases such an assumption similar to the fact that humans can make perfectly accurate evaluations and computations. This is not always possible without the help of

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perfectly designed logarithm and computation devices. One would have great difficulty in delivering such a flawless result under normal/reasonable circumstances (that is when the person is making computed evaluation and are not under any physical/mental distress or discomfort). People make an enormous number of decisions every day, and many of these decisions are not made based on a set of perfectly executed decision-making theory algorithms. Instead, people are likely to make decisions usually based on their own judgement, experience and perception. Sometimes, these decisions are even made under duress, or occasionally with little rationality (Agosto, 2002).

It is not difficult to observe that references and relative utility play important roles in real life situations when it comes to decision-making. This does not mean that decision theory is useless; it does, however, imply that the theory cannot be applied blindly in all situations. Since there are flaws to the assumptions of decision theory, and the fact that people usually do not behave in the ways consistent with strictly axiomatic rules, there are other disciplines of decision theory that incorporate relaxed assumptions (Bertrand & Fransoo, 2002). The discussion below delves into some aspects of other decision-making scenarios.

### **Decision-making Under Uncertainty**

The topic of choices made under uncertainty represents the heart of decision theory. This is also of great relevance to the discussion on patients' decision regarding whether or not to use PHI in a public hospital. To begin with, when faced with a number of actions, each of which could give rise to more than one possible outcome with different probabilities, the rational procedure is to identify all possible outcomes, determine their values (positive or negative) and the probabilities that will result from

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each course of action, and multiply the two to give an expected value (Chase et al., 2010). The action to be chosen should be the one that gives rise to the highest total expected value (utility). When many factors surrounding decision making are unknown the decision-making process under these uncertainties involve a range of factors that may seem reasonable by the decision maker, but the results of decision may be viewed as irrational by others (Brock & Wartman, 1990). People tend to be risk averse when making decisions under uncertainty, for example, if there is a small risk to a decision which could lead to catastrophic consequences. It is likely that the decision maker would avoid taking such risk. However, if it is clear that the small risk could lead to significantly better consequence, then there is a likelihood that the decision maker would be willing to take such risk.

## **Prospect Theory**

Prospect theory is a behavioural-economic theory that describes decisions between alternatives that involve risk, where the probabilities of outcomes are known (Kahneman & Tversky, 1979). This theory states that people make decisions based on the potential value of losses and gains rather than the final outcome, and that people evaluate these losses and gains using interesting heuristics. The developers of this theory, Kahneman & Tversky (1979), argue that the decision-making process has two distinct stages: editing and evaluation. In the editing stage people decide which outcomes they see as basically identical; however, a reference point is set, enabling the decision maker to consider lesser outcomes as losses, and greater ones as gains. In the evaluation phase that follows, individuals compute a value (utility) based on the potential outcomes and their respective probabilities, and then choose the alternative that has a higher utility.

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When prospect theory is applied at a rudimentary level of PHI utilisation, a patient would tend to consider what the likely outcome would be if they were to use PHI. However, the concept of using PHI to some patients means uncertainty, as they tend to believe that there are additional costs involved. If there are free alternatives, such as Medicare, the patients reasonably believe that the preference of a free option is less risky and more attractive. In particular, the outcomes of higher utility (value) in this incidence could mean that they can spend less to obtain the same outcome (equal quality of treatment). However, under this theory, if additional value of using PHI is introduced (that is, if there is a higher perceived additional utility for using PHI), then the patient would re-assess the value of using PHI. It is reasonable to assume that being that Medicare is the free and most common form of financial choice that a patient would elect, it is therefore used as a default reference point by people who then compare it with other alternatives when admitted to a public hospital.

Kahneman and Tversky (1979) have indicated that the concept of 'loss aversion' is people's tendency to prefer avoiding losses to acquiring gains. Kahneman, Knetsch and Thaler (1990, p.1326) state that "the generalization that losses are weighted substantially more than objectively commensurate gains in the evaluation of prospects and trades". That is, if the value is the same, people perceive losing something of value as higher risk than gaining something of equal value. For example, a person's satisfaction loss in losing a \$20 in a bet is higher than the satisfaction gain in winning a \$20 bet. In the context of PHI utilisation, when a patient is faced with the decision of to whether or not to use PHI, the patient could use loss aversion as one of the rationales in the decisions. That is, even though the perceived value (medical treatment) may be the same when a patient enters the emergency department, tendency by the patient to avoid loss (paying an excess/co-payment or something unknown) is probably stronger than if they were to gain anything through



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using PHI. It seems that something needs to be introduced to reduce the patient's potential loss when using PHI. On the other hand, based on loss aversion theory, there appears to be less need to dedicate extra value for people for using PHI when compared to the need to reduce the potential loss.

Kahneman and Tversky (1979) found three regularities — in actual human decision-making, "losses loom larger than gains"; persons focus more on changes in their utility-states than they focus on absolute utilities; and the estimation of subjective probabilities is severely biased by anchoring. It is important to examine the three regularities that Kahneman and Tversky (1979) have concluded above, and identify their relevance to decision-making regarding PHI.

Firstly, Kahneman and Tversky's (1979) statement that "losses loom larger than gains" identifies the irrational behaviour of human beings when it comes to decision making. For example, to a patient, the potential personal loss of convenience (e.g. the patient may consider that "I might receive a bill if I elect to be a private patient and may have to spend my time to sort the bills out even if I won't have to pay the bill at the end anyway") may seem to be a lot larger loss (a personal utility loss) than the fact if the patient utilises their PHI and may be eligible to a single room (a personal utility gain), can assist the hospital (ultraisms satisfaction) and may be entitled to a free toiletry pack (a personal utility gain) as too little of a gain. However, others may view this choice from a different perspective, and it therefore seems that the regularity identified by Kahneman and Tversky (1979) contains some relevancy in the topic of PHI utilisation decision-making.

Furthermore, Kahneman and Tversky have stated that individuals tend to focus more on changes in their utility-states than they do on absolute utilities. This point also seems to be quite relevant to the issue of PHI utilisation decision-making. For

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example, if people are used to the loss aversion option related to being admitted to a public hospital as a public patient, they would indeed focus a lot of their attention on the issue of changing from one utility of free healthcare (being a Medicare patient), which they are accustomed to, to another utility of using their PHI in a public hospital (they have paid for their care through their PHI premiums; so even if they do not use their PHI cover, they have nothing to gain or lose anyway, as the insurance premiums are already paid for). From an observer's perspective, such a decision-making process would seem that the decision maker (the patient) would have to have had a strong focus on the fact that they have changed their utility from one state to another (Weiss, Weiss & Edwards, 2010). The focus in the matter of PHI utilisation decision-making is that, regardless of whether the change of state is from less ideal to more ideal or vice-versa, the simple fact that the utility (or the status-quo) has changed is a matter that the decision maker tends to consider carefully. In this instance, if a patient is given the choice of choosing between the ordinary status-quo, i.e. Medicare-funded (free) treatment or a treatment funded by an unknown option, i.e. using PHI if the patient has not had experience using it before. In this decision-making process, the patient will be focusing a lot of their attention on the fact that the utility has changed, but if the alternative is an unknown or has any slight negative connotations, then the patient would be likely to hesitate to pick the unknown option.

Moreover, Kahneman and Tversky (1979) have stated that the decision-maker's estimation of subjective probabilities is severely biased by anchoring. The concept of anchoring will be discussed in later sections, however, in simple terms, anchoring refers to a cognitive bias that describes the common human tendency to rely too heavily on the first piece of information offered (Madhavan & Wiegmann, 2005). In the situation of PHI decision making, since the utilisation of Medicare is the norm, this acts as an element that "anchors" the patient's decision-making, probably

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because using Medicare is the only way to be admitted to the public hospital. Also, if the patient hears stories about other people using PHI where they either have been charged or had a negative experience, then they would tend to be less likely to use their PHI due to the influence of anchoring.

Prospect theory has been used in many discussions regarding decision making; however, it has some limitation in its application. For example, when a person makes a decision, it is possible that they are not bound by any particular decision-making theories, and their decision might sometimes be even random. Human nature has many aspects of irrationality and randomness to it, and these cannot be always explained by a theory, although most people do follow a certain type of routine in their decision-making process (East, Lomax, Willson, & Harris, 1994). Furthermore, it should be recognised that prospect theory should probably be used in conjunction with other theories in order to explain some of the decision-making processes wherein prospect theory may not cover some of the decision-making aspects.

### **Bounded Rationality**

Another school of thought – “bounded rationality” theory – evolved within the decision-theory discipline, and posits that humans are not capable of making absolutely rational decisions. However, this related decision theory still has some relevancy to real life if relevant assumptions are adjusted accordingly. Bounded rationality is the idea that in decision-making, rationality of individuals is limited by the information they have, the cognitive limitations of their minds, and the finite amount of time in which they have to make a decision (Dequech, 2001). Wettersten (2012) suggests that some models of human behaviour in the social sciences assume that humans can be reasonably approximated or described as

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"rational" entities. Economists have conventionally assumed rational behaviour, and can "in large enough quantities be approximated to act according to their preferences" (Yalman, 2007). The concept of bounded rationality revises this assumption to account for the fact that perfectly rational decisions are often not feasible in practice, due to the finite computational resources available for making them.

Herbert (1991) describes a number of dimensions with regards to decision-making, along which "classical" models of rationality can be made somewhat more realistic, while sticking within the vein of fairly rigorous formalisation. These include:

- Limiting what sorts of utility functions there might be;
- Recognising the costs of gathering and processing information;
- The possibility of having a "vector" or "multi-valued" utility function.

From the analysis of a number of aspects of decision theory earlier, and based on the review of some limitations of the related theory assumptions above, bounded rationality appears to provide a more relevant view of decision theory, and it is more closely aligned to reality. When looked at closely, bounded rationality in the context of this study can show important relevance to the decision by patients of whether or not to use PHI.

Like any other type of theory, the bounded rationality approach does no doubt have its own limitations. Bounded rationality has a reputation for being used as a sort of catch-all category that can "explain" all observed deviations from maximising rationality (Casson & Wadeson, 1996). The Herbert dictum that man applies "intended rationality, but only limitedly so" is an example. The saying implies that it is almost useless (and therefore non-predictive) unless the rationality decision process is coupled with other assumptions (Hodgson, 2007). This means that the application

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of bounded rationality is subject to a vast range of assumptions and dependencies to provide it with some level of rationality, otherwise the decision-making process is not at all appropriate or rational. Since the variability is so changeable, and assumptions so vast, practical application of the bounded rationality approach can be limited. In reality, bounded rationality is a way of understanding that the decision-making process cannot be completely rational due to dependencies, assumptions and limitations (Größler, 2004). It does, however, present usefulness in the process of gaining an understanding of the decision-making process in a particular scenario; given the limitations in said given situation, the human being may tend to make the decision with the most utility or maximum value to him/her based on available information, time and resources.

For example, if a patient is waiting in the emergency department (ED) waiting room to be seen by a doctor, the decision of whether or not to use PHI is based on the ability of the patient at the time to calculate the maximum utility and the effect that the decision will have on him/her. Depending on how well the patient's physical condition may be, the patient's decision about PHI could be either well considered or not at all. It is not possible to argue that the patient has had made a fully rational decision – the patient may be in pain and therefore be unable to dedicate any computational power to calculating the utility.

One unique theory found during the literature search was on the irrationality of people's decision around purchasing and using PHI. Ariely's (2008) theory on predictable irrationality argued a distinctively different perspective to other studies, whereby it asserted that people's decision about purchasing a product was inherently irrational. Natalier and Willis (2008) also argued a similar case to Ariely (2008). They asserted that people do not go through a calculated reasoning system

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when evaluating the decision about purchasing insurance; instead, the decision is based on experiential learning, trust, language, cultural and the generational inheritance. Although Natalier and Willis (2008) did not extend their study into the actual utilisation of PHI in hospitals, their theory of irrational decision-making was backed by empirical evidence, and the result appeared trustworthy. Also, the result from Natalier & Willis' study result bared correlations between the theories of irrationality of decision-making and human inconsistency.

### **3.2. Factors Which Affect Decisions**

#### **The Service-value Factor**

Scholars in the marketing discipline may often argue that services related to health and customer service are very different from physical products. One important feature that they allude to is the concept of price as an indicator of quality. It has been argued that as there is often the asymmetry of information about the services offered; people cannot make a rational decision about whether or not a service is good, but they price is an indicator that they can relate to (Toncar, Alon & Misati, 2010). Using their past life experiences and outcomes as reference points, they may believe that services that cost more mean that they are of higher quality.

In services-marketing theory, without evidence to suggest otherwise, price, to a consumer, can often indicate both the level of service costs and the level of service quality. The tendency for people to choose a service that costs more is likely to be a risk reduction mechanism (Harris & Emrich, 2007). Prices set for a particular service sometimes indicates the service quality, and it can therefore influence the level of expectation that a consumer has of the service prior to encountering it. So in some

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ways, a high price tag may be viewed by consumers as an implicit promise of high-quality service.

This concept has some relevancy in the role of PHI within the public healthcare arena in Australia. Since Medicare is seen as a free service (even though most people are liable for a Medicare levy), when people compare free public hospital care with paid private care, they tend to assume that the private care quality is better (Willcox, 2001). While the interpretation and meaning of better healthcare quality could be varied depending on individual, it is, however, likely that people who are encouraged to use PHI would like to see aspects of their care being better than that of someone who does not use their PHI.

### **Likely Financial Loss**

When there is a “free” option to receive healthcare, people would seldom choose another paid option unless there are strong compelling reasons to do so (Bisset, 1997). There is a strong possibility that people may consider the use of PHI as a form of insurance activity similar to the principal of car insurance policies (Harley & Willis, 2013). That is, there may be the belief that people who are insured must pay an excess to obtain the benefit of the coverage, and such risk is perceived as undesirable, especially when they could instead use the alternative “free” (Medicare) option. People’s perception of such undesirable outcome would deter them and reduce their motivation to use PHI.

### **Likely Increase In Premiums**

Similar to what has been discussed above, there may also be the belief among PHI members that using PHI would directly result in the increase of premiums, as

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consumers consider the PHI principle to be similar to that of car insurance. That is, the consumers may have the false belief that a PHI premium is based on the risk profile of the individual and that people who claim more are likely to be penalised by needing to pay a higher premium. There could be a certain percentage of the patient population relying strongly on this belief in their decision-making, and therefore would therefore not disclose their PHI details when being treated at a hospital.

### **Anchoring In Decision Making**

It is suspected that some patients may have been influenced by the common belief of anchoring. In this context, anchoring is signified by the fact that some patients believe that seeing as though they have been paying their taxes for years, there is little reason for them to use their PHI, when instead they can get a their fair return on the tax they have paid in the past. In other words, paying their taxes and Medicare levy appear to be an arrangement that they can concur with, and they are unwilling to expose themselves to any unnecessary financial risk associated with using PHI.

### **Social Values**

When it comes to socio-political leanings, if a patient comes from a traditional Labour background or strongly supports the public welfare system, they could be of the opinion that the government should be paying for their healthcare without understanding that even universal healthcare does not come without cost. It is possible that these patients may have a strong belief that the public healthcare system should not treat their neighbours, family or peer reference group any differently. Furthermore, there is the sense that PHI is a last-resort option, and given that little information is really known about PHI, many patients would rather not exercise their PHI unless it is absolutely necessary.



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## **Political Views**

In Australia, with the increasing public expectation placed upon public healthcare services provision, the public healthcare system has been under a lot of scrutiny and receives a lot of negative press coverage. There could be groups within the patient population who believe that the government has been cutting back on public money to hospitals. These patients believe that if enough of them use the public service and ensure that public hospitals have enough patient footfall, it will reflect that the community needs the public hospital to exist and funding to be adequately provided. They may also believe that by doing this, the government has a tougher time to cut hospital budgets. In this environment, if a person exercises their own PHI cover, the hospital will receive less government funding, as money from the health fund is being subsidised by the PHI companies.

## **Decision Effort**

Another aspect in the PHI utilisation equation could be to do with the fact that extra process is involved with electing to be a PHI private patient. It is quite possible that patients dislike paperwork, and taking time to fill in scrolls of paperwork is therefore not desirable. Furthermore, using a Medicare card and being admitted as a public patient requires less effort than electing to be a private patient; this option also involves less unknown factors (or risk). These factors contribute to the effort consideration of patients in their election of health-related financial matters.

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## **The Role Of Ignorance**

There could be the possibility that some groups of patients do not know what the outcomes of exercising their PHI in public hospitals really means, and due to a fear of risk (or the unknown) they decide not to use PHI. From one perspective, the role of ignorance is also related to the amount of effort that might be involved with the decision making of PHI.

## **Cognitive Overload**

Importantly, it should also be noted that people come to hospitals because they are sick and in need of medical attention. Their main attention is usually focused on how to get well fast or to better cope with their body's physical condition. It is quite possible that some patients may feel too ill to think about economic matters, as the matter of their health is the primary issue that is loading their cognition. In these circumstances, it is likely that PHI decision-making is less rational than when a person is in a calm and collected frame of mind.

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## **4. Literature Review: Financial Decision Making And PHI Utilisation In A Public Hospital**

This chapter continues with the literature review but delves deeper into the decision theories for financial matters and explores a wider spectrum of issues that could influence PHI utilisation decisions in a practical hospital setting. It looks at a range of factors and problems which may affect the way how some decisions are made.

### **4.1. Major Factors Affecting PHI Utilisation**

#### **Situational Factors**

A number of psychology literatures have explained the concept of situational impact on decision-making. In short, this theory states that people's decision on a given issue is likely to change depending on the type of situation that they are in (Eleswed, 2011). For example, a person who is normally calm and collected would usually make sound and logical decisions about a problem; however, the same person might behave very differently when confronted by a very stressful situation. The theory would imply that when a person is under duress (external) influence, for example, it affects their decision-making. In a hospital setting, when the patient has a medical condition that requires attention, their priority focus tends to lean towards their health and wellbeing. This therefore affects their decision-making regarding financial matters, and they may behave differently at these times when compared to when they are calm and when there is no impending need to seek medical attention. Thus, when a decision is made regarding financial matters, one cannot directly apply ordinary decision-making theory to a hospital context.

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## Decision And Motivation Factors

The decision by patients to choose whether or not to use PHI has relevance to the motivation behind why such a decision has been made. In the academic world, theories of motivation have been evolving for many decades (Bernard et al, 2005). Some of these theories focus on organisational theory and people management, whilst other theories focus more on the basic human motivation factors from a general psychological perspective. Other theories have merits that can be applied in both a practical managerial sense and also from a human-motivation perspective. Maslow's (1943) hierarchy of needs is one of these theories that displays such features, and is useful to scholars when examining motivations behind PHI-related decisions.

Maslow's hierarchy of needs lends its relevancy in the discussion of financial decision-making in the healthcare setting in relation to a patient's decision-making process when it comes to using PHI., especially when under physiological duress (e.g. in pain, feeling dizzy or feeling feverish) (Maslow, 1943).

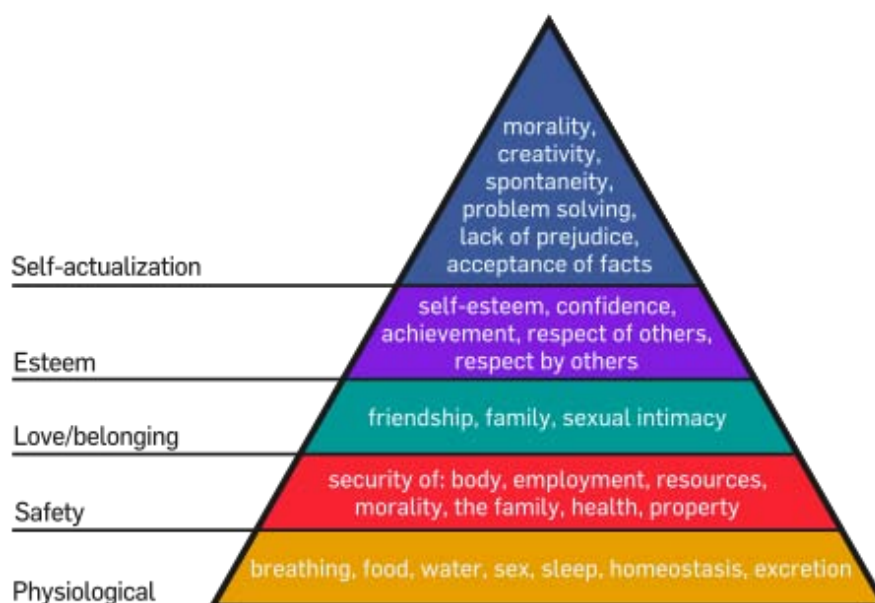


Figure 13. Maslow's Hierarchy of Needs (1943)

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Safety and security needs include:

- Personal security
- Financial security
- Health and wellbeing
- Safety net against accidents/illness and their adverse impacts

It is not difficult to recognise that these basic needs are similar to what patients are likely to experience when they are entering a hospital's ED due to health problems that require immediate attention. One could argue that when patients are in this situation, it is likely their basic safety needs of health and wellbeing tend to be more important than financial safety and the associated decisions about using health insurance. It is likely that patients would not always make a rational decision regarding using PHI when their safety, physical condition and wellbeing are being compromised; this is because the matter at the forefront of these patients' minds is probably that of receiving treatment quickly and recovering, and since they are under physiological stress, their judgement and decision-making is likely to be less rational. On the other hand, one could argue that from a patient's perspective, their decision to focus on how to recover is the most important matter, and by not considering other things to be more important, they have therefore made a decision that they believe fitting to the situation at hand.

It should be noted that there is also a group of patients who may be able to rationally consider how they would be financially affected by their decision to use either PHI or Medicare.

However, there are other non-emergency pathways to the hospital wherein the patients would have fewer or less prominent safety or physiological concerns than

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they might if they were to make an urgent visit to the ED. For example, when patients book in for an elective surgery, the patient would most likely have decided whether or not to use their insurance prior to coming to the public hospital. The amount of uncertainty related to finance-related decision-making is minimal in these scenarios. In most cases, when an elective surgery patient goes to the hospital, he/she has already made the decision about whether or not to use their insurance. One should also note that although there is a high propensity for patients with high levels of health and safety concerns in the ED, it is not possible to fully generalise that all of these patients experience the same type of health and safety concerns. This could also mean that some patients with a lower propensity towards health and safety concerns may be in a suitable frame of mind to make sound financial decisions.

### **Historical Development Of PHI**

Discussions regarding the decision and motivation on private health insurance utilisation in above sections provided a brief background of the relevancy in this chapter. Here, a detailed review talks about the historical development of PHI and how individual motivation and government PHI policy changes inter-relate.

Various historical developments specifically regarding the Australian healthcare system and PHI were discussed in the previous chapter on Health Funding. The Federal Government's PHI incentives and development of related policies were aimed at alleviating the pressure on the public healthcare system through increased uptake of PHI (Menadue & McAuley, 2012). This chapter will examine the literature encompassing the financial decision-making process of people purchasing PHI and using PHI both in private and public hospitals.

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Munn and Wozniak (2007) examined the roles and responsibilities of the public and private sectors in the Australian healthcare system. The paper summarised a series of incentives the Australian government had introduced in order to promote the purchase of PHI by individuals. Similar to the previous section's summary, this thesis also noted that these policy incentives included lifetime health cover, Federal Government rebate for PHI, and the Medicare levy surcharge. Munn and Wozniak stipulated that in general, these policy changes had been effective in promoting the uptake of PHI by individuals. According to PHIAC, as of December 2006, 43.4% of the Australian population purchased PHI for hospital coverage; an increase from 33.6% in 1996.

One of the problems in Munn and Wozniak's work is that it was not empirical. It was unclear exactly how effective certain measures had been in promoting individuals' choice of PHI purchase from a psychological decision theory-perspective. However, it provided the valid argument that PHI policy changes that would affect individuals after tax income had been effective in increasing the take up of PHI. This viewpoint was also supported by the work of Sundararajan et al. 2004. Similarly, Sundararajan et al. (2004) drew evidence to demonstrate that policy changes by the Federal Government had indeed been effective in increasing the percentage of the population holding PHI. All these findings were consistent with PHIAC's statistics on the amount of PHI take up. It was evident that these policy instruments mentioned previously had been effective in encouraging more of the population to purchase PHI cover.

In order to explain why people chose to use their PHI cover in a public hospital, it may be useful to gain an understanding of why they have purchased the health cover in the first place. A number of studies have attempted to explain the underlying

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reasons behind why people choose to purchase insurance, one having been conducted by Buchmueller et al. (2009), who used the data obtained by the NHS, where the respondents could provide multiple answers to the question. It has been found that the most common reason for purchasing was that: PHI provides a sense of security or peace of mind. These people tend to report slightly better health than the ones without PHI cover. Another large group of respondents related their reasons to shorter waits, ability to receive care in a private hospital, and the ability to choose their own doctor. The respondents in this category reported better health than did the uninsured, but there was a greater incidence of long-term conditions among these respondents. Almost 20% of respondents stated that their reasons for the purchase were due to financial considerations, such as avoiding a tax penalty. These individuals have a significantly higher-than-average income, and tend to be significantly healthier than average. 18.5% of insured people explained that either they always had it, their parents had it or they had it as part of their employment conditions (see figure below).



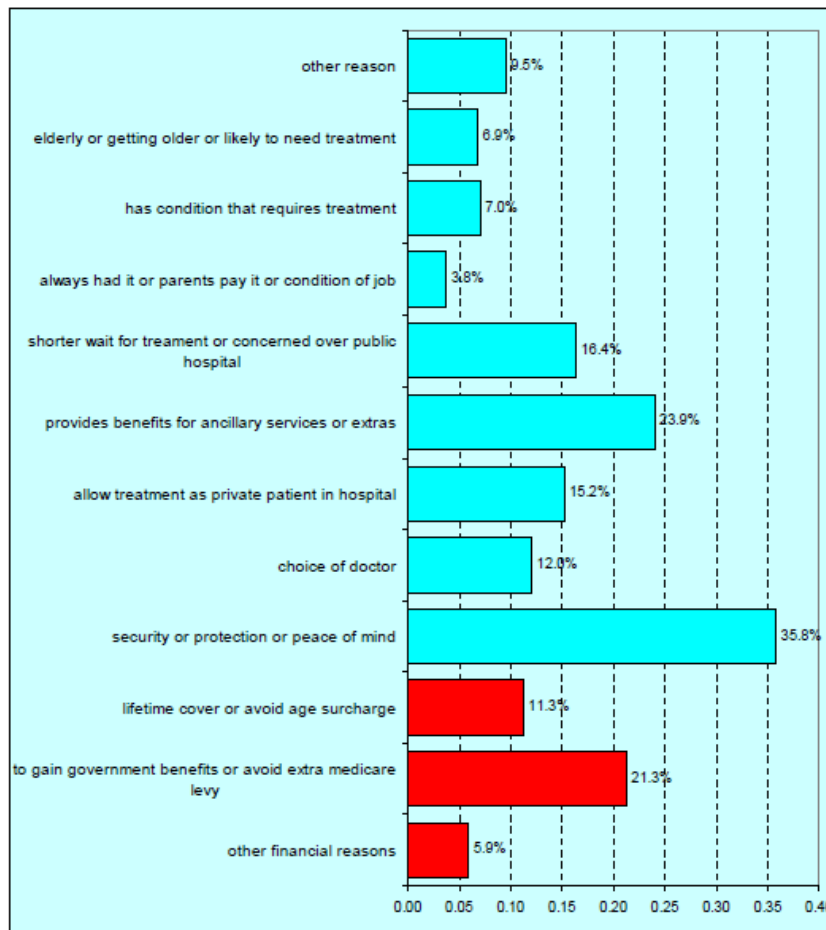


Figure 14. Reasons for purchasing PHI (Buchmueller et al., 2009)

In an article by Apps, Rees, and Wood (2007) their analysis drew on household survey data to show that female labour supply is strongly positively associated with household saving, the purchase of PHI and spending on family health generally. While the paper by Apps, Rees and Wood (2007) did not focus on the topic of PHI as its main study area, its sociology study on matters pertaining to factors influencing people's decision to purchase PHI has some value in understanding the people's thought processes. However, this article did not discuss the thought processes when people were deciding whether to use PHI in a public hospital; instead the majority of the article focused on the government's tax policies and its effectiveness of the population purchasing PHI.

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A paper entitled “Will subsidising private health insurance help the public health system?” by Vaithianathan (2002) assessed the effectiveness of subsidising PHI, and attempted to explain the rationale around why certain groups of the population chose to purchase PHI. Vaithianathan (2002) asserted that a person who has never anticipated using the private healthcare system was unlikely to purchase PHI. Vaithianathan’s paper explained in detail why some people chose to purchase PHI, e.g. that they had their own choice of doctor or that the quality of accommodation in a private hospital is higher. However, Vaithianathan’s paper was flawed in its assumptions; it ignored the fact that there was a population of patients who would still choose to use their PHI in a public hospital. In this thesis, much emphasis has been placed on assessing the effectiveness and impact of the policy on the private healthcare system versus the public healthcare system. Conceptually, the researchers have designed a flawed, clear-cut view that patients with PHI were only likely to use their PHI and receive care in a private hospital, whereas people who did not hold PHI would only rely on the public system. Finally, Vaithianathan (2002) did not study the decision motives behind why some PHI holders choose whether or not to use their insurance in a public hospital.

Also on the implications of PHI policy development, from a separate study conducted by Ellis and Savage (2008) it was understood that in addition to the impact of increased enrolment by 50% they have also reduced the average age of enrolees. More importantly, it has been found that the major drivers of the increased enrolment into PHI are a response to a deadline and an advertising blitz, rather than a pure price response. However, it should be recognised that the income distribution and tax penalty also played part in encouraging people’s uptake of PHI.

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A separate paper by Walker et al. (2007) cited a data analysis conducted in 2001 by TQA Research, which indicated that for patients with PHI cover, 31.2% used public hospitals and 68.8% of patients used private hospitals. Although this study did not then go into detail to examine whether the patients who declared their insurance status actually used that insurance, there is reason to believe that not all of the 31.2% of privately insured patients used their insurance during their hospital stay. This weighted study was based on a telephone interview involving 5194 interviewees from all areas of Australia. This again opened up questions as to the psychological decision-making process behind patients having chosen not to use their insurance. It has also been pointed out by Duckett and Jackson (2000) that there was a fundamental contradiction in the current healthcare arrangements in Australia, whereby the provision of free hospitalisation in public institutions; co-exist with what is essentially full cost recovery in the private sector. It is important to understand from these literatures that a portion of people who do hold PHI are not using them in public hospitals.

According to a Galaxy Research survey (Browne, 2012) of more than 1000 Australians, it was found that people were more likely to choose PHI for its ancillary benefits rather than basics such as better-quality healthcare, choice of hospital or choice of doctor (Browne, 2012). Among those with PHI, 82% rated extras cover as the single most important benefit. The two most popular lifestyle extras are massages, nominated by 39% of policyholders, and plastic or reconstructive surgery, nominated 37% of people with PHI. Other popular benefits for policyholders include gym memberships, named by 25%, Yoga or Pilates (24%), sports shoes (17%) and dietary supplements (16%). The findings revealed a shift away from basic cover for ambulance and hospital services towards lifestyle extras.

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During this part of the literature search, it appeared that a large amount of literature had described and analysed policy impacts on increasing the level of the population's PHI cover in Australia. However, a detailed analysis, from a psychological-decision perspective, of the decision of whether or not to use their PHI in a public hospital was generally lacking among the literature. An absence of this knowledge meant that there was, in general, a lack of understanding of why some people chose to use their PHI in a public hospital. Conversely, there was also an insufficient understanding of reasons as to why people chose not to use their PHI in a public hospital, except from anecdotal presumptions that in general, people think public hospitals are not the "right" place to use their PHI, whereas the private hospitals are the "right" places. This anecdote and these assumptions may require supporting evidence in order to discover whether or not they are indeed the facts.

### **Statistical Facts Relating To Private Health Insurance**

During the literature search, statistical archives were reviewed for the purpose of gaining an in-depth understanding of the topic area. One such data source was the Australian Bureau of Statistics' (ABS) 2004–2005 NHS (2006). It should be noted that the data made available via the ABS was for the country as a whole, and was not broken down by LGA. It is therefore important to note that the data obtained here may not be generalisable to every geographical region in Australia. This data does, however, provide some indicative figures in helping to understand the Australian population's PHI status from a national-census perspective.

According to the ABS's 2004–2005 National Health Survey (2006), the likelihood of having PHI increases with income. In 2004–05, 23% of people in the lowest income quintile had PHI compared with 76% of those in the highest income quintile (after adjusting for age differences) for the same period.

Similarly, 28% of people living in the most socio-economically disadvantaged areas had PHI, compared with 72% of those living in the least socio-economically disadvantaged areas (as measured by being in the lowest and highest quintiles of the index of disadvantage, respectively). (These data have been adjusted for age differences.)

It is noted in the abovementioned 2004–2005 NHS that the likelihood of having combined hospital and ancillary cover is strongly related to income, whereas hospital-only and ancillary-only cover do not differ significantly by income group. Of those in the highest income quintile, 62% had both hospital and ancillary insurance, compared to 14% of those in the lowest income quintile (after adjusting for age differences).

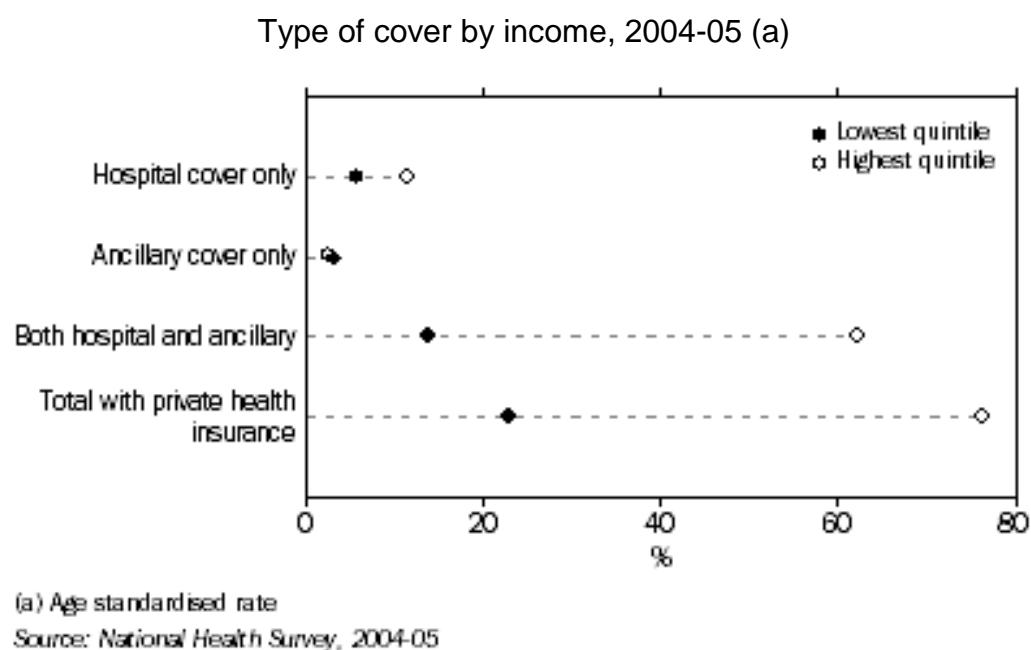
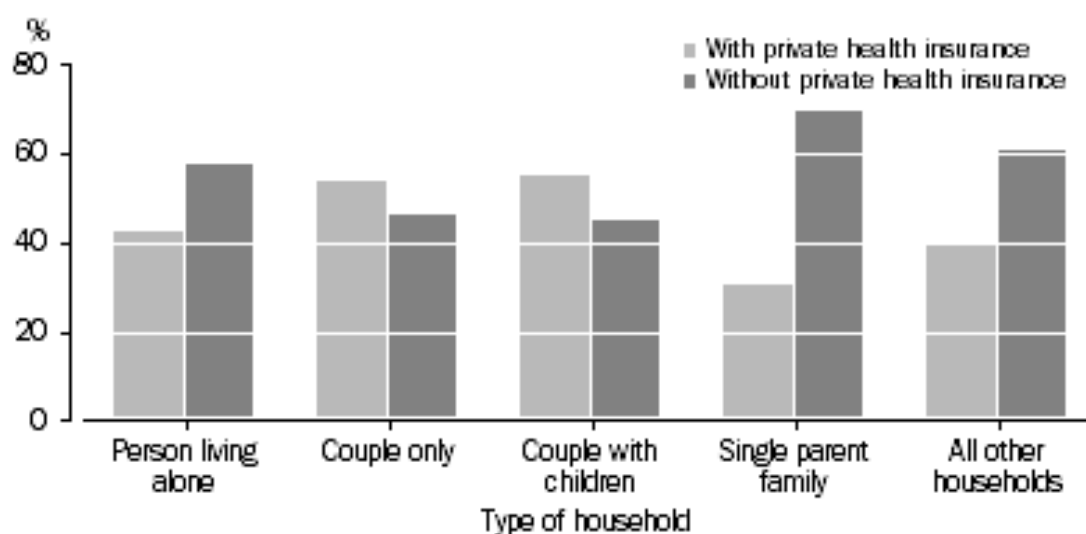


Figure 15. Type of cover by income, 2004–05 National Health Survey (Australian Bureau of Statistics, 2006)

Based on the 2004-05 National Health Survey data, the rates of PHI uptake were the highest among couple-with-children (55%) and couple-only (54%) household types (after adjusting for age differences). Single parent-family households were least likely to have PHI (30%) – they were the most likely to have a health concession card (60%) (after adjusting for age differences).

It can also be noted that employed persons aged 15–64 years were much more likely to have PHI (56%) than those who were unemployed (22%) (after adjusting for age differences). By contrast, 59% of unemployed persons in this age group reported having a government health-concession or entitlement card, compared with just 11% of employed persons. These phenomena can further confirm the point above, that is, that people with less income are less likely to have PHI cover, whereas the likelihood of having PHI increases along with increased income.



(a) Age standardised rate

Source: National Health Survey, 2004-05

Figure 16. PHI Coverage 2004–05, National Health Survey (Australian Bureau of Statistics, 2006)

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## Types Of Cover

According to the 2004–05 NHS, most people with PHI had both hospital and ancillary cover (75% of the insured population). Hospital and ancillary together was the most common form of cover across all insured age groups, from 57% in the 75 years and over age group, to 77% in the 25–34-, 35–44- and 45–54-years age groups.

Hospital-only cover was more commonly reported by people in older age groups (40% in the 75-years and over age group, and 24% in the 65–74-years age group), while ancillary only cover was most common in younger age groups (9% in both the 15–24 and 25–34 years age groups) for those with PHI.

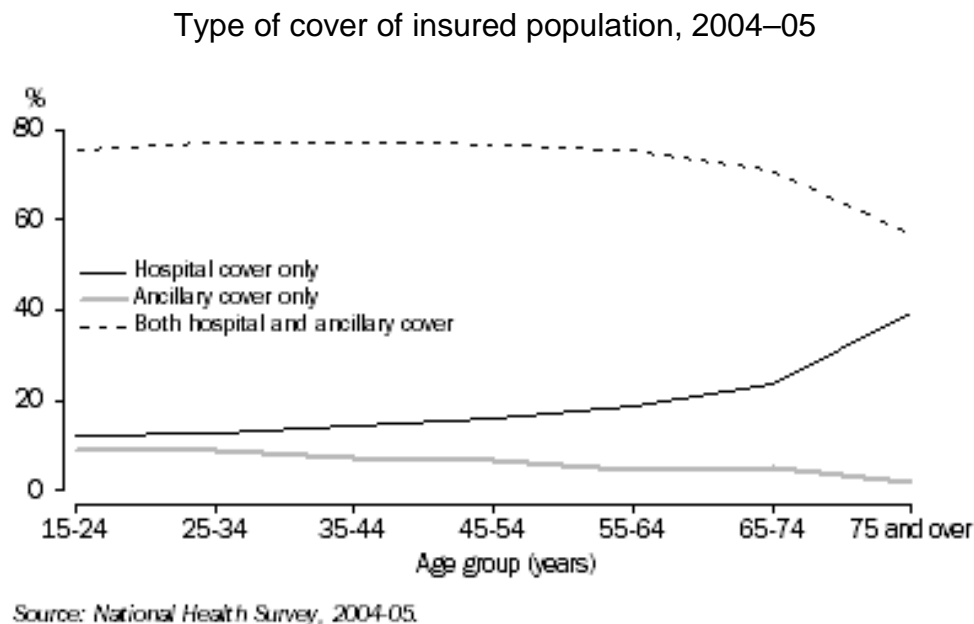


Figure 17. Insurance status by household structure, 2004–05 (a)

National Health Survey (Australian Bureau of Statistics, 2006)

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As of 31 December 2012, 10,710,319 people (46.9% of the population) were covered by hospital treatment cover (PHI hospital cover) according to PHIAC (2012b). This represents a slow but steady increase in PHI membership across the nation. There is generally a much lower percentage of the population with ancillary-only cover than people with PHI hospital cover.

## **Health Status**

In 2004–05, 62% of those with PHI reported that they were in excellent or very good health. An estimated 35% of those who reported that their health was fair or poor had PHI.

For example, 61% of all people in the 45–64-years age group had PHI – 42% of this group having ischemic heart disease, 49% having long-term mental and behavioural problems, and 55% having arthritis or diabetes – were privately insured. By contrast, those aged 45–64 years with sinusitis or hay fever were more likely to have PHI (63% and 65%, respectively). Taking into account those with a government health-concession or entitlement card, over 80% of those in this age group with the conditions shown were covered by PHI and/or a card.

## **Risk Factors**

Data obtained from the 2004–05 NHS suggests that in most age groups, those adults who smoke and/or drink alcohol and are therefore at a high-risk level were less likely to have PHI than other people in the same age groups.

Of the estimated 3.2 million Australians aged 18-years and over who smoked daily in 2004–05, 32% had PHI (ABS, 2006). In all age groups, the proportion of daily



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smokers with PHI was at least 20 percentage points lower than that of non-smokers. The largest difference was in the 45–54 year age group, where 39% of daily smokers had PHI, compared with 68% of non-smokers.

In all age groups, people aged 65-years and under and classified as high-risk alcohol consumers were less likely to have PHI than those who consumed at lower-risk levels or who did not drink alcohol (ABS, 2006). The largest difference was in the 35–44- and 45–54-year age groups, where the proportion of high-risk drinkers with PHI was 13 percentage points lower than the proportion of other people in that age group. For the 65-years-and-over age group, the levels of high-risk drinkers who had PHI were similar to that of others in that age group.

An estimated 47% of the population aged 15-years and over were classified as overweight or obese. Just under half (49%) of these people had PHI, compared with 53% of persons who were an acceptable weight or underweight (after adjusting for age differences) (ABS, 2006).

## **Public Hospital Admissions**

This chapter has a strong focus on public hospital emergency admission as there is only a very small number of emergency departments (three in total) attached to private hospitals in NSW. Patients who go to a private hospital emergency department is outside the scope of this thesis as they do not likely have barriers in using their PHI to cover their private hospital visit. This is because private hospital admission is a user-pay system and patients would need to fund their admission through either their own funds or by using PHI upfront.

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Some patients who visit public hospital via the emergency department do not end up being admitted. These patients, even if they held PHI, would not be able to use their PHI cover because it is only applicable for admissions. An admission does not have to be signified by patient being allocated a bed and physically staying in a bed, however, a doctor usually decides that an admission should be made only if it is deemed clinically necessary. For example, sometimes, an admission in the emergency department, could be deemed clinically necessary because the patient is required to stay for observation, or had to remain in a hospital's short-stay area. However, any decision made by the admitting doctor would be an opportunity for the patient to use their PHI if they hold eligible hospital cover.

It should be noted that in the 2004-05 NHS, 20% of people with PHI who were admitted to hospital in the previous 12 months and had reported their most recent admission had been there as a public (Medicare) patient.

The main reasons reported by insured people for admission to hospital as a public patient were that the choice had been made by others (26%), the choice was made on a doctor's advice, or their doctor had booked them in (23%) (ABS, 2006).

### **The Issues About Excess And Gap**

There is a large variety of PHI products in the Australian market. According to PHIAC, these products are offered by 36 registered health-fund providers, as of March 2012 (PHIAC, 2012a). These various insurance products, sometimes referred to as policies, are designed to suit the different needs of consumers. Some policies contain hospital admission-based cover, some contain complementary cover only (extras such as dental, physiotherapy and rehabilitation care), while other, more comprehensive policies include the whole package that covers hospital stay,

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complementary medicine, dental care and physiotherapy. In this research paper, the core discussion on PHI primarily focuses on the type of health fund policies that contain hospital cover. This is because only people who hold insurance that contains hospital cover are eligible to use their insurance in a public hospital for inpatient admissions.

Generally speaking, depending on the type and level of PHI cover, some insurance policies require an excess (co-payment) payment from the user when they are claiming benefits from the health fund. This excess is payable regardless of whether or not the patient was admitted into a private or a public hospital. This is similar to car insurance when claiming cover for an accident. The reasons for an excess payment in an insurance sense are mainly to deter abuse and to maintain the profitability of the insurer (Young, 1972). Applying this principle to the PHI context, people who really need PHI cover will be more likely to pay for their excess, and an excess payment would be effective in deterring anyone who tends to waste or abuse the insurance cover. Although this principle seems fine from a health fund's perspective, from a patient's perspective, eliminating possible abuse may be seen as limiting their choice of healthcare provider, because when seeking treatment to come up with a co-payment, someone with health problems will be more likely to consider using the "free" public healthcare system, especially when no marked difference is observed between the private and public healthcare option. In such a scenario, the major beneficiary is the health fund, because the excess almost acts as a barrier to the patients' willingness to use their health fund, and there would therefore be a reduction in the amount of benefits that the health fund would be paying to the health provider.

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On the other hand, there are also other insurance products that do not require an excess payment; this means that the users do not have to make a co-payment when seeking treatment privately. It is possible that some of these products are likely to cost more in monthly premiums, as user co-payment is not required. Some other types of insurance without excess could be due to the number of years that the member is with a particular fund, similar to a loyalty discount scheme (Robinson, 2003).

Another important matter to consider in PHI utilisation is the concept of gap payment. Essentially, a gap payment is what the doctors would charge the patients above the Medicare schedule fee (the “no-gap” or “bulk-billing” rate), or when a hospital charges over or above what the patient would get back from the PHI fund (Hall, 1999). Usually, if a doctor does not bulk-bill (that is, when they charge above the no-gap Medicare schedule fee, and the doctor is at liberty to do so) then the patients would need to pay for the gap payment if it is not possible for such a gap to be covered by the health fund. The government does not set doctors' fees, and the doctor is free to decide on a case-by-case basis whether or not he or she wishes to use an insurer's gap-cover arrangement. Some health funds have gap cover arrangements to insure against some or all of these additional payments. Some health funds have gap-cover doctors' agreements made with particular doctors that may cover all or some of the doctors' fees for the patient's hospital treatment. If the patient's fund does not have an agreement with the treating doctor, then the patient may have to contribute towards the doctor's bill out of their own pocket. It should also be noted that sometimes patients are looked after by more than one doctor (for example, a surgical patient could be treated by a surgeon as well as an anaesthetist), if the patient is having an elective procedure there is the opportunity and less urgency to discuss fees with the doctor. However, if the patient is visiting the hospital

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for an emergency procedure, there would be less opportunity for the patient to consider use of PHI and discuss their fees with a doctor.

Some private hospitals have arrangements with PHI funds, whereby the health funds agree to not charge the patient a gap. In most of the cases, public hospitals do not usually have arrangements with any private health funds, but they can also waive gaps for patients who choose to use their PHI.

In a 2012 research report published by IPSOS Australia, it has been found that one in five people using a public hospital have PHI, and that one in 10 Australians admitted to a public hospital had PHI but chose not to use it (IPSOS, 2012). The report states that the reason as to why one in four people decided not to declare their PHI when being treated in a public hospital was because they were trying to avoid expensive gap payments. The article also states that whilst the public pay a large gap payment that is not usually covered by the health fund or Medicare, these OOP costs are implemented by doctors who charge above the Medicare schedule fee, and it is likely that this would have an impact on PHI usage.

For medical procedures covered by the MBS, usually the healthcare insurer will fully cover the cost of at least one prosthesis, if required (this is sometimes called a “no gap” prosthesis). In some cases, an alternate prosthesis may be available which could cost more than the “no-gap” version. If one of these prostheses is used, the patient will have to pay the difference between the “no gap” amount and the total amount charged by the supplier of the prostheses.

There is a general assumption that people attending a public hospital emergency department in NSW would be less likely to use PHI if they had to pay an excess or any type of OOP expense. This assumption is based on the fact that patients know

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that they could receive care as a Medicare patient at no cost, and in light of this free option, people are less likely to deviate from it. There is also a general assumption that people attending private hospitals as booked elective-surgery patients would have a higher willingness to pay for an excess or any OOP expenses (if payable). This assumption is based on the fact that specialists and surgeons would generally explain the financial implications (usually what cost would be incurred) to patients prior to treatment to a hospital. In addition, people who are likely to use the private hospital service are generally making a conscious decision to receive care that may not be free, and as such have specific reasons for utilising private care.

### **Issue About Waiting Period**

Generally, when starting a new PHI policy, patients will either have to serve a waiting period or increase their level of cover. A waiting period is put in place to protect the health fund's existing members by ensuring that new members are not able to make a large claim shortly after joining and then cancelling their membership, as this kind of behaviour would result in increased premiums for all members. The waiting period therefore acts to reduce the negative financial impacts to all members. Also, in order to reduce financial risks and costs, a health fund may impose a 12-month waiting period on benefits for hospital treatment for a pre-existing condition (Private Health Insurance Act, 2007). Therefore, for members who are still serving a waiting period when they are admitted to a public hospital, even though they may be willing to use their PHI, they may sometimes be prevented from doing so. Or sometimes this could mean that they would be financially much worse off if they used their PHI instead of coming in as a Medicare patient.

### **Patient Decisions About Using PHI**

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According to Lu and Savage (2006) people who purchased PHI but are not using it as much as they would (in circumstances where they should) because they can and probably are continuing to use the MBS. Although this statement was not based on an empirical study, the assumption is made based on observations that because insured people have access to both the private and public system in parallel, they may be inclined to choose the simpler and least financially risky option, i.e. the MBS. Shiell and Seymour (2002) found one of the possible explanations for this phenomenon in a paper discussing the preference for health cover. It has been found that individuals may be motivated not only by the factors that may satisfy their own preference, but also by the sense of contribution to the general good of the community/society. An earlier study on the public's view of the Australian healthcare system indicated a strong support for the publicly funded system (McKie & Richardson, 2011). Using Shiell and Seymour's findings, it could be argued that some people who chose to use PHI may have done so due to their altruistic reasoning, being that the support of the public healthcare system is important, and thus electing to use their PHI in a public hospital to assist the hospital in caring for its community by justifying the need for government funds. On the other hand, one could say that public healthcare should remain free for the public, and that the insurance companies should not be "taken advantage of" by others.

From the aforementioned studies regarding the reasons why people choose to purchase PHI, there appears to be a theme denoting correlations between people's reasons for purchasing PHI, and their reasons for whether or not they would choose to use of PHI in a public hospital.

A study conducted by Srivastava and Zhao (2008) indicated that a person with PHI hospital cover and someone with a higher income have a much higher chance of

opting for private treatment in a hospital or getting treatment in a private hospital. However, people who took out PHI purely for financial reasons were unlikely to use their PHI for fear of OOP expenses (Fiebig, Savage, & Viney, 2006) (the OOP is similar to a co-payment/excess in a car insurance policy: in order to make a claim, the insured person has to make a co-contribution to the cost of that claim; this is seen by some as a means of preventing people from excessively claiming). The result of people not using their PHI in public hospitals was shown in the 2004–2005 NHS, where nearly 20% of those who had PHI cover and were admitted to public hospitals chose to be treated as public patients during their most recent hospital visit (see Figure 18 below for graphical representation). This study indicates that there is a large amount of the population with PHI cover still choosing to rely on the public MBS. Although there is no in-depth explanation of the reasons behind such behaviour, the study does emphasise that the amount of people not using their PHI in public hospitals is significant.

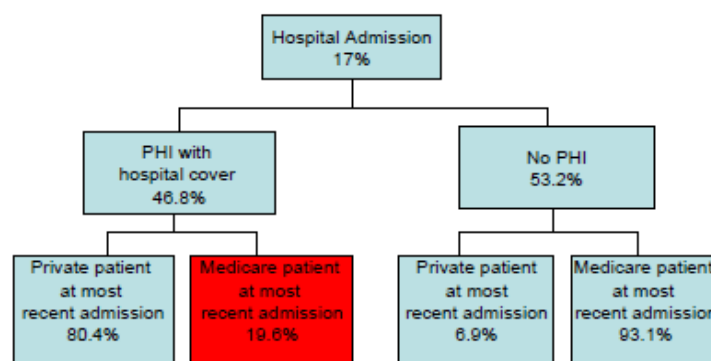


Figure 18. Hospital admission and private health insurance utilisation (Srivastava and Zhao, 2008)

One of the key findings from Fiebig, Savage and Viney's (2006) study was that there was a significant association between choice of public or private healthcare and factors such as length of waiting list, the ability to choose the doctor, date and



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location of treatment. These factors would have a varied impact on individuals' choice of whether or to use public or private healthcare; these would also impact on the decision making around whether or not to use their PHI cover if admitted to a public hospital. In addition, the perceived value of the quality of care could also be an important determining factor in affecting the patient's decision between receiving private or public care (Goddard and Smith, 2001). In this instance, private care could denote both a private patient in a public hospital and a private patient in a private hospital.

### **Entry Points To The Hospital**

Generally, there are a number of relatively common patient entry points to NSW public hospitals. One of the first major entry points is emergency presentations via the hospital's ED when a patient requires immediate care after an accident or in an emergency situation. These presentations to the hospital are often not pre-planned and people may not have had time to think about whether or not to use their private health insurance. Patients entering the hospital ED could come to the hospital by various means, for example: on foot, by motor vehicles or via an ambulance.

Another major entry point to public hospitals in NSW is via the planned elective-surgery corridor. People who have been booked in for admission to a hospital via this pathway would most often have had the chance to discuss financial elections to cover their healthcare with their specialist doctors. Usually, through this discussion, the decision around choice of hospital (either private or public) and whether or not to use PHI are often decided prior to the patient attending the booked procedure. The nature of elective surgery is a planned, considered process; this thesis will be

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touching on this point often, as it is often different from an unplanned ED visit, wherein the use of PHI and choice of care may not be clearly considered beforehand.

Other forms of entry to public hospitals include referral from the patient's GP to attend the hospital's ED; transfers between hospitals (from public to public or vice versa) due to clinical needs or available resources; and ambulance transfers from an aged care facility directly to an inpatient ward or to the hospital's ED. The amount of opportunities for deciding whether or not to use PHI via these forms of entry to public hospitals often varies; however, those with a Medicare card who also hold PHI would often choose not to declare that they have PHI, and would instead elect to be registered as a public Medicare patient.

### **The PHI Story At Canterbury Hospital**

Inpatient PHI billing revenue has been an important focus at Canterbury Hospital; there is an ongoing drive to improve revenue by increasing the number of inpatients utilising their PHI. Between 2010 and 2012, there has been significant success in doing so. The majority of this improvement, to date, has been through an increase in the numbers of patients who have entered the hospital through the ED using PHI, with limited success in increasing private patients entering the hospital through other pathways. This success was made possible by the introduction of the Emergency Private Inpatient (EPI) financial class at Canterbury Hospital. Under this arrangement, patients who entered the hospital via the ED, and who had later on been admitted as an inpatient, could choose to use their PHI. All admitting doctors at Canterbury Hospital have entered an agreement to say that they would not charge the patient a gap (that is, the fee they charge would be covered by the health fund without the

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requirement of a patient-funded co-payment), and the hospital would waive the patient's PHI policy excess.

There are generally three options for how admitting doctors could be remunerated for the work they perform with patients admitted under the EPI financial classification:

1. To bill patients at the schedule fee only (if they are insured);
2. To bill patients at the no-gap rate if these patients are covered by "gap cover" by their health fund, and the doctor is registered with the fund to bill no-gap treatments;

Doctors who bill patients who choose to be private under the above two arrangements possibly forego the extra fees they are able to collect as gap payment, however they may benefit from more patients choosing to offer private treatment so that they can bill the health fund rather than the hospital, which would usually mean a higher potential income for the doctor.

3. To not bill the patient, and for Visiting Medical Officers (VMOs) to charge the regular hourly rate to the hospital (similar to the process used with public patients).

Doctors who do not bill patients choosing to be private under this arrangement forego the extra fees they are able to collect as gap payment or higher income from the health fund, but this means less paperwork and administrative duties for the doctor. To not bill the patient, and for VMOs to charge the regular hourly rate to the hospital (similar to the process used by public patients), this means that the patients will not be receiving a bill from the doctor. Some doctors prefer this option, as the timesaving factor may be a big incentive to them.

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The introduction of EPI is a result of understanding that a large number of patients choose not to use their PHI cover due to fear of OOP expenses and associated financial risks. The agreement for doctors to adopt an EPI financial classification is dependent on the following conditions:

- It will only apply to patients who have entered the hospital through the ED;
- It will not apply to the charging of elective admissions;
- It will not affect those patients who are covered by workers compensation, third party, Department of Veterans' Affairs (DVA) or chargeable overseas visitors;
- If a patient requests to be the private patient of their preferred doctor upon entry into the ED, they will be admitted as a traditional "private inpatient" (PI) (regular private patient who is treated by their own nominated doctor). In this circumstance, doctors would decide on whether or not to charge these patients.

There is another arrangement for those patients who visit Canterbury Hospital for maternity services to also benefit from similar treatments above, if they choose to receive treatment under the self-insured pathway. This arrangement allows doctors to bill patients Medicare rebate only (if the patient is not insured and paying the hospital costs themselves). For patients who are self-insured, this option allows them to incur less of a financial burden.

From the information above, it is not hard to see that that arrangements have been made by Canterbury Hospital to reduce the financial risks for doctors in accepting to treat private patients entering via the ED corridor; however, most importantly, these arrangements reduce the financial uncertainties for patients deciding whether or not

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to be private. The introduction of the EPI financial class and its associated arrangements has virtually removed the financial obstacles that could discourage patients from using PHI if they were to be admitted to the hospital via the ED. By reducing or eliminating the financial obstacles or risks, such measures allow patients to rethink the use of PHI for their public-hospital admission.

According to the ABS (2006), 28% of persons living in the most socio-economically disadvantaged areas hold PHI with hospital cover. In Canterbury Hospital, for the financial year 2010–2011, an average of only 10% of all patients used PHI.

While people who live within Canterbury Hospital's catchment area live in one of the most socio-economically disadvantaged areas in Australia, with the potential of at least 28% of those people being likely to have health insurance, one could argue that there is still a significant potential opportunity to increase the number of patients using their health insurance. However, it must be noted that it is incorrect to assume that nearly 28% of patients who visit Canterbury Hospital hold PHI with hospital cover. In fact, some may argue that patients with PHI tend to be relatively more health conscious (or may tend to have more disposable income) than those who do not have hospital cover, and it may be likely that they are making efforts to stay healthy. Some may also argue that people with PHI are more likely to use their insurance outside the public healthcare system. However, there is also the argument that those people who know that they require more frequent healthcare due to poor health are more likely to purchase PHI – so regardless of them having a higher income, they purchase PHI to avoid risk.

Over the financial year of 2010–2011, just under 50% of all patients at Canterbury Hospital entered the facility through the ED, and 16.84% of those patients became private inpatients. But for the other half of the patient population of Canterbury

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Hospital, that is, patients who entered via the elective admission corridor, this statistic was 3.41%. The hospital has therefore identified that there is a potential to increase the number of patients using their PHI from all pathways into the hospital, with the greatest potential now appearing to be in elective admissions. It should be noted that although it is predicated that there is a potential for improving PHI utilisation conversion rate, because there is no LGA-based PHI membership data, it is not possible to identify the PHI membership rate. Also, as hospital-based data on patient PHI membership is only indicative of the number of patients declaring themselves as holding PHI, it is not possible to identify people who do not declare themselves as having PHI.

Over the two years of writing this thesis, much work has been done at Canterbury Hospital to make it as easy as possible for patients entering the hospital through the ED to use their insurance through the introduction of EPI financial class; however, there are many variables out of the hospital's control with regards to elective admissions. These variables include:

- Doctors' discussions with patients and patients' choice
- Patients' interactions with their health funds
- Time for patients to consider options
- Confusion for patients regarding their levels of coverage in a public hospital

In order to understand the aspect of PHI and what happens when patients enter the public hospital, it is useful to find out what steps are involved in a typical patient's journey. In addition, it is important to understand patients' interaction with the hospital staff and with the various processes during their admissions, and how these

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multiple factors relate to the patient's decisions regarding PHI utilisation. The following section looks at these typical patient journeys.

### **Typical Journey Of A Patient Entering The Hospital Via The Emergency Department**

When a patient enters Canterbury Hospital via the ED:

- The patient approaches the front desk clerk to inform the staff member of their problem. The front desk clerk asks them if they have a Medicare card and/or a PHI card for basic information registration.
- The front desk clerk then gives the patient a registration form to complete, and the form is to be handed back to the front desk clerk once completed. The form also requests that the patient provides information of PHI details.
- A triage Nurse will call the patient in order of initial arrival, and will then place them in a category box located in the clerk's front office for further investigation. The triage process is to determine the severity of a patient's condition; more urgent conditions will be seen first.
- When the patient hands the registration form back to the clerk, that clerk will complete and further generate a patient personal information sheet (name, age, date of birth etc.), including patient identification labels.
- The patient is then either directed to wait in the ED waiting room, or to a bed in the ED, depending on their condition and diagnosis.
- Once the patient is directed to a bed in the ED, they are seen by a Doctor for assessment. The patient is then either admitted to the hospital for further assessment/treatment, or discharged home.

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- If admitted, the ED team leader is notified and will admit the patient onto the inpatient computer system. Whether or not they are an overseas visitor, privately insured or if there are other possible fees to be paid, the clerk then admits the patient for interview and explains to the patient information regarding their financial classification. This crucial step is how an in-depth interview takes place to identify and determine a patient's financial classification, and if successful, the patient would decide on using their PHI cover for that particular admission.
  - The ED team leader then books a hospital ward bed with the bed manager on duty. The team-leader then hands over the patient to the ward nurse before transfer.
  - A porter is then notified of the transfer to relocate the patient. The team leader then marks the patient off from the inpatient system to be electronically transferred to the wards. This completes the process of an ED admission.

### **Typical Journey Of A Patient Entering The Hospital Via Booked Admissions**

Patient enters Canterbury Hospital via a booked admission.

- When a patient sees a GP, and if in the GP's opinion that further review is needed, the patient will often be given a referral to see a specialist doctor in a particular clinical discipline.
- The patient then makes an appointment with the specialist. The specialist makes a decision as to whether or not the patient needs to have a particular procedure. The specialist can be someone who works in a public hospital full time, which means they would usually only refer someone to a public hospital.



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However, if the doctor is a VMO, they would usually have some sort of private association with the hospital, which means that it may be possible to admit the patient for a procedure that would be performed outside the public hospital. In addition, it should be noted that a staff specialist who works solely in a public hospital can still treat a patient in a private capacity, which means that the doctor and patient would negotiate an agreed fee for the proposed service provision.

- The financial decisions regarding the specialists' fees about a patient's procedure are made in the doctors' surgeries. Depending on the discussion about where, how and when the procedure would occur, the patient may go to a private hospital, a private day surgery or a public hospital. If the patient is referred to a private hospital or surgery, there may often be OOP expenses and a doctor's gap and accommodation co-payment that the patient is liable to pay. These fees may or may not be fully covered by PHI, depending on the patient's level of cover and the negotiation with the doctor.
- The patient will then be directed to the admissions office with a recommendation for admission (RFA) form from the specialist.
- The admissions office will then check the form to identify whether or not the patient is a Medicare patient, PHI (or private) patient, overseas visitor, or self-funded. The patient is then directed to the finance department.
- The patient will then see the finance department's cashier or a private patient officer, by whom they will be informed of hospital costs, hospital accommodation and any excess, all of which is to be paid on the same day of booking. This step is applicable only to non-Medicare patients; that is, private patients and overseas patients.

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- All patients must present photo ID on the same day. All the financial paperwork and election forms are to be completed and signed in the hospital's finance department. Once these forms are completed, the patient is instructed to return to the admissions office to lodge the paperwork for admission.
  - The admissions staff will then send a letter to confirm that the patient is on the admissions list. The letter also contains the date/time and other necessary information relating to the patient. They will then further confirm via telephone call to the patient to verbally state the date/time and necessary information for the patient's admission and procedure. They will also mention whether or not the patient will initially need to go to the pre-admission clinic.
  - It should be noted that the pre-admission clinic is an outpatient clinic-based service to assess the patient's health condition, primarily from an anaesthetic-services perspective. Not all patients would need to go to the pre-admission clinic, but for those who are required to visit the clinic, there are additional interview opportunities, the chance to identify whether or not they hold PHI; as well as the potential to convert them to becoming a private patient.
  - Once this process is complete, the patient would proceed to the next stage of their elective-admissions process – surgery/procedure. On the designated procedure date, the patient is then admitted to the operating theatre on the day of surgery. The theatre's reception clerk will ask the patient for either a Medicare card or a PHI card, as well as about how they intend to pay if any payment is required. They will then verify whether or not these details (e.g. date of birth, age, current address) are correct.

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- The patient will then receive the clinical procedures, and will either be discharged or transferred to a hospital ward after the procedure. It is clear that when a patient is admitted to the hospital via the admissions process, there are many steps and opportunities wherein patients could potentially decide to use their PHI, and it should be noted that these elections would not normally happen automatically – they would instead require some sort of interaction with hospital staff who could provide the patient with information and assist them in making these financial decisions. Every patient contact point is an opportunity for these interactions to occur.

### **Political And Social Beliefs**

An individual's political or social belief in the construct of phenomena around them may affect the way they behave (Kenny & Jenner, 2008). Previous studies that have supported the theory that people's decision on financial matters are not rational suggested that myths, beliefs, and misconceptions can have a significant impact on an individual's decision. For example, an individual who has been brought up with a traditional working-class Labour background may believe that free-for-all universal healthcare is a human right. They probably also hold PHI membership due to fear of inadequate cover or other reasons, but may be less likely to declare having insurance, let alone using their PHI cover in a public hospital. Their exact motivation for not using PHI can be quite complex, however this belief, although not processed through evidence-based cost/benefit studies is, nevertheless, deeply held by the person due to their own value systems.

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## Increase In Premiums

Unlike car insurance, PHI policy premiums in Australia are generally not based on risk profiles or claim history. For example, out of two people on the same PHI product (with same/similar cover), the person with far worse health condition who claims several times a year compared to another person in better health and who does not claim at all will pay the same insurance premium (Paolucci et al., 2011). Under the close monitoring of PHIAC, PHI funds are limited in order to increase the cost of the premium that they charge, based on client-risk profile, i.e. how much or how little a client uses the cover. However, it should be noted that not all aspects of the premiums are well-understood by the clients. It is highly probable that there is a common misconception by many people that using their PHI would affect their premium payment, very much like a car insurance claim. However, it was difficult to determine such misconception due to limited amount of empirical study result.

Some scholars have argued that the Australian experience of PHI is that premium rises do not significantly deter membership (Cheng, 2013). It has been noted that the demand for health insurance has always been marked by relative price inelasticity (Industry Commission, 1997). In economics, that represents a relatively low price sensitivity versus demand for PHI. Butler (1999) has argued that the risk aversion associated with a lack of confidence in access to public hospitals under Medicare has long-underpinned the appeal of PHI, and is quite immune to price. In other words, there is evidence to suggest that the price of premiums has little effect on how many people would be enrolled as part of PHI.

It is unclear how well the general public understands the relationship between their premium payments, insurance claims and policy excesses. As mentioned earlier,

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some people believe that the more they use their PHI the more premium, the more they will need to pay next year. Others believe that the amount of premium they pay has no significant relationship to how much they claim against the insurance.

The survey tool employed in this study aims to ascertain what conception or misconception exists among patients attending hospitals and what they believe in from a financial-election (in particular, PHI) perspective. This tool would cover their understanding of premium payment, their knowledge about PHI and a range of aspects of the PHI topic.

### **Healthcare As A Service & How It Impacts On PHI Utilisation**

When studying the important topic of PHI utilisation, it should be noted that the very existence of PHI is to offer a healthcare service to meet the needs of the population. Like many other types of service in the services-marketing discipline, the healthcare-marketing service has a number of distinctive features. Services are vastly different from physical products; most services cannot be inventoried (perishable); healthcare service is mostly intangible; and healthcare services are often difficult to visualise and understand. In the case of services-marketing, people are often involved in the co-production of service (Arnold, Palmatier, Grewal, & Sharma, 2009).

These theories, on the surface, are very business-oriented and do not appear to have any relationship with PHI utilisation; however, when viewed in perspective, it has some relevant links to how PHI and healthcare services are viewed in the eyes of patients. This stems from the fact that healthcare is a service and people's experience of receiving a healthcare service sometimes affects their future behaviour. The decision to use PHI may also provide an indicator to suggest whether or not the patient was happy with the care they received. Put simply, when entering the hospital, patients when making their financial elections are advised that using PHI

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helps the hospital and the local community; it is the patient's choice as to whether or not they choose to use PHI instead visiting as a public patient. However, on the other hand, patients who are not happy about the service they received may be less inclined to elect to use their PHI, as using PHI is not compulsory.

It is understood that consumers are likely to behave differently towards product offerings compared to service offerings, because the very nature of products and services are different (Harris & Reynolds, 2003). An understanding of the features of services, and in particular, healthcare services, would help scholars and professionals to gain an understanding of how it relates to people's decision-making process about using their PHI. The preference of whether or not people would choose to use their PHI is also associated with the main purpose, receiving health care service.

Past history of PHI utilisation may also be an indicator in predicating whether the patient is likely to use their PHI again, as well as if they are likely to provide positive advice to their family and friends about their healthcare experience, or whether, in their opinion, PHI utilisation was a good idea.

Additionally, the provision of healthcare services shows an asymmetry of knowledge, that is, the healthcare-service providers are in a very powerful position, due to the fact that they possess intrinsic knowledge about how healthcare services work. On the other hand, the patient as the service-receiver has very little or no information or knowledge about the services that they are about to receive from their healthcare professionals. This lack of expert knowledge held by patients could often leads to anxiety and the tendency to avoid risks. The issue of risk avoidance is therefore something that patients value greatly when they are encountering health-related problems. Put simply, people who are in ill health tend to want to get better using the

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easiest and least risky way (that is, a conventional method of treatment), and when they seek medical treatment, they are likely to avoid any risks associated with their treatment. For people who have traditionally only used the public hospital system, this is their default conventional treatment provider, and to avoid any risk, they are likely to venture down this avenue.

Healthcare services provided by health-service providers (either at a private or a public hospital) are of a heterogeneous nature. In the services-marketing framework, this means that unlike physical products, services are often performed by people, and the same service, even if performed by the same person, is rarely ever the same. Within a health-services context, it is assumed that patients would like to obtain consistent, high-quality care from their health-service provider. Unfortunately, based on the theory of services-marketing, in reality, the same type of healthcare services provided by clinical professionals is not always the same. It is also probable that the same clinical treatment provided by the same clinical professional to the same patient can vary in itself, even from its first treatment to the second treatment. This is simply due to the unique feature of services.

However, from the patient's own perspective, it is possible to assume that they believe that services or treatment provided by the same doctor are always consistent. Therefore, it is possible to hypothesise that, as a way to reduce inconsistency and risk, the same doctor is preferred by the patient, as they are familiar with the expectation and service experience. The election of the doctor of one's choice is usually done the choice to be a private patient or a self-funded patient in a public hospital. Patients can of course also choose to be treated in a private hospital via the doctor's own private arrangements with the patient, all of which depends on the patient's choice. It can be seen from these examples that patients' utilisation of PHI

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has a strong relationship with the nature of healthcare and patient experience of using PHI as a type of service.

There are prominent features of healthcare service offerings that help to demonstrate how the consumer's view on utilisation of PHI may be affected; these are as follows:

- Intangibility
  - Health service is physically intangible, as the service itself is not something that can be touched or felt; however, the outcome of good health service is something that the patient can feel;
  - The health service offering is relatively difficult to grasp, and once consumed, the service quality is usually judged based on an evaluation of the outcomes.
- Heterogeneity
  - Health services production systems are complicated and highly specialised; repetition of the same service even by the same service provider are different from one time to the next due to the inconsistent nature of human behaviour;
  - Patient/consumer's needs and expectations are different; what one consumer may consider to be a good service (e.g. type of treatment, level of customer service and a private hospital's amenities, may be different from those offered by a public hospital to public patients) could be different to another patient's expectations of public hospital care;



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- Standardisation and automation of health service cannot be as easily applied as standardisation and automation in manufacturing businesses, as the production process is different from that of manufacturing physical products.
  - Inseparability
    - Service itself is identical to the service-production function, it is rarely separated from said service-production function;
    - In manufacturing, it is possible to put the end product into storage or inventory once manufactured; services, on the other hand, cannot be separately put into inventory – they are often consumed during production;
    - Service producer and customer have to meet; the service cannot exist with just the producer (e.g. a patient has to participate in the production process of his/her treatment).
  - Perishability
    - Physical products generally tend to have longer life span compared to services, while services are often consumed during production;
    - Once produced with the participation of a consumer, the health-service production process and service-consumption process are both complete.

Some examples of the differences between physical products and services are as follows:

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- In the airline industry, empty seats can be sold before the gate closes, however, such service then becomes unavailable when the aeroplane departs;
  - Another example is that of a hairdressing service; the service cannot be produced without the presence of the customer, the co-producer of service – the customer must be present for the service to be delivered;
  - Lastly, in the example of surgical-service provision, when a patient receives surgical treatment, the service is highly personal, and the outcome of the treatment is experienced only by the patient, and is yet not always physically tangible.

There is a range of reasons as to why hospital health services are being compared to products, and their relationship with PHI utilisation is also discussed here. Firstly, it should be noted that there are certain reasons behind why customers tend to feel risky when purchasing services compared to purchasing goods. Customers know very little about the service that they are buying; goods are produced beforehand and it is relatively easy to compare prior purchasing, but services, on the other hand, are relatively harder to compare, as they are produced while being consumed, and there is usually no prior comparison available to the consumer. For example, buying a T-shirt from an online store is something usual, typical, and the customer usually knows what to expect from the product. However, this experience is different from that of visiting a hospital or using PHI for a public hospital stay, as it is relatively difficult to evaluate the service gained from a hospital treatment, or the difference between using or not using PHI. This is because even with the same service provider, there could be variations in aspects of the service such as duration and quality of service, and if it is the customer's first time they might not know what to

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expect. However, if the customer has experienced such a service before, then they might be able to compare this admission with past experiences.

The experience of PHI utilisation is a similar story here; someone who has visited the hospital previously, and who has used their PHI and received care that they perceive to be good, may use their PHI again the next time, as this prior experience would have led them to believe that using the PHI did not in any way adversely affect their hospital stay. However, if the patient has received certain benefits during their stay as a PHI patient, then it is likely that this would influence their perceived service quality positively, and may impact their decision to use PHI the next time they visit the hospital.

Consumers are typically wary about the uncertainties involved in purchasing a service due to the characteristics of services (Lian & Laing, 2004). New services especially, where limited evidence and very little information is available to be used for comparison, further increases the perceived risk or uncertainty. Complex services such as health services are likely to have a strong asymmetry of information available between service provider and consumers. For example, medical and clinical services are highly specialised, and doctors and clinicians are professionals with years of training, whereas average consumers would not have had such training and it is therefore harder for those consumers to know what these services are going to be like.

To minimise the types of perceived risk by consumers, there firstly needs to be a thorough understanding of these risks. By understanding such risks, it can provide health service managers with unique insights in understanding the underlying reasons as to why certain decisions are made by patients when it comes to consuming health services. The following are some of the typical risks associated

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with services and their related examples in a healthcare-services setting, and what type of questions that patients are most likely to be concerned with:

- Financial risk, e.g. would the consumer need to pay the cost of the insurance excess to cover the claim of healthcare if he or she uses their PHI?
- Functional risk, e.g. by using PHI, would this in any way affect the specific treatment fulfilment required by the consumer (patient)?
- Physical risk, e.g. will the health service consumer wake up from the operation after surgery? Does this risk present any further risks associated with the use of PHI?
- Psychological risk, e.g. would the consumer feel better after the treatment? Would they feel assured about the quality of service provided if they used their PHI?
- Sensory risk, e.g. would the consumer enjoy the public hospital stay in terms of its clinical service, food, customer service, ambience, etc. compared to other alternatives?
- Social risk, e.g. would the consumer enjoy his or her social interaction with the people that they may come across during their stay?
- Temporal risk, e.g. if the patient chooses to use PHI, would he or she receive the surgery in time?

### **Methods that consumer can employ to reduce perceived risks**

To an extent, for a patient who has not had experience in utilising the PHI in a public hospital, the decision to do so appears to be a somewhat risky matter, as it is not an experience that the patient is familiar with. It has been noted that sometimes, what

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concerns the decision maker is not what the new choice is, but rather the simple fact that a new decision will be made. That is, changes in the status quo, which appears to be an unknown to a person, is what concerns the decision maker the most (Knoll, 2010). For PHI fund corporations, it may not be in their best interest to promote the use of PHI in public hospitals, as there are relatively less financial incentives for these funds if patients choose to do so in a public hospital as opposed to in a private hospital. As private health funds do not actively promote the fact that PHI can be used to cover the patients' public hospital stay, many patients do not think that public hospitals are the appropriate place to use their PHI. This has also been supported by the findings of the survey: a very large portion of respondents did not know that they could use their PHI in public hospitals. A lack of knowledge about the ability for them to use their PHI in public hospital is one aspect, and questions then also begin to emerge regarding how consumers and patients could reduce their perceived risk of using PHI. Incorporating the findings from this study, some solutions for reducing barriers preventing patients from using PHI are discussed in this chapter.

- Seeking information from respected personal sources (such as family or a friend)
  - A consumer who has had experience staying at Canterbury Hospital as a private patient, and who had a prior positive experience, may be likely to share their view of this experience with their friends and family;
  - On the other hand, if, as a private patient, the person did not have a good experience, the consumer would probably also tend to discuss it with others or emphasise the fact that the hospital was not a good one, or that it was not a good idea to have used their PHI for their stay;

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- It may be of relevance that, even though the patient's PHI election process might be smooth, and that the patient had no qualms about using their PHI, if their hospital stay was not a good experience, then it is likely that they would attribute such negative experience to other aspects of their hospital treatment or care, including the choice of using PHI, thus further affecting their future decisions;
  - This has some important implications for PHI utilisation; for example, a patient who did not have a good experience in the hospital as a private patient may tell someone they know that going to Canterbury Hospital was not a good idea, as the experience was not good;
  - It is possible that even though PHI utilisation may not be the central theme that overshadows a patient's hospital stay, their treatment experience, on the other hand, is likely to be an important factor that would prompt a patient to share stories of their experience with others;
  - If a patient received some benefits as part of the PHI, and if the PHI benefits were worth sharing, it may be a way that PHI utilisation could be promoted through the word-of-mouth communication method. However, one aspect that needs to be considered is the patients' privacy, as some patients may also choose not to share with others the fact that they spent time in hospital. This is highly dependent on the individual's level of comfort in sharing such information and, and their motivations for doing so.
- Comparison of independent reviews and ratings

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- Independent review sources or testimonials from other patients or consumers who have used their PHI can provide powerful insight to potential PHI users into what using PHI was like;
  - Having portrait photos of the individuals who made these comments may also be a way to increase to visual images than plain text, and putting a face to some text tends to increase the effectiveness of the communication based on experiences had in other hospitals;
  - Rely on a reputable source (for example, checking official or government-authority announcements about particular topics);
  - Also, for example, in deciding where they would like to go out for dinner, some savvy consumers may compare consumer reviews from websites (such as [eatability.com.au](http://eatability.com.au) or [urbanspoon.com.au](http://urbanspoon.com.au)). Similar strategies could be implemented regarding PHI use through newsletters and patient information materials.

It is imperative to note from the empirical study that one major misconception by patients about the issue of PHI utilisation is due to “I didn’t know that private health insurance was covered by public hospital stay”. This tends to show that patients are not aware they could use their PHI for their public hospital admission. Other misconceptions such as the fear of OOP expenses and other unknown risks are also strong barriers in preventing patients from using PHI, on top of the possible cognitive overload when patients are under physical stress when they are in ill health.

Based on the above understanding, it can be inferred that patients sharing their positive experiences of using PHI could be a way of presenting independent reviews and references to other potential PHI users. Patients with PHI who have not yet

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declared or used their PHI may use these references as something that they can relate to personally, which might help them during their decision-making process.

- Offering of guarantees & warranties
  - For example, in the building industry, written guarantees for building works are usually common practice in improving consumer confidence of their workmanship;
  - In this instance, consumers (patients) could find out if the hospital provides written guarantees to patients that they would not incur any OOP expenses, or if there is assistance in reducing patients' uncertainty or anxiety when faced with unknowns, e.g. when patients' paperwork for PHI election needs to be completed. Such guarantees help to reduce the number of unknown risk factors for patients.
- Trial aspects of service pre-purchase (e.g. a trial piano class before committing to the studying course is considered useful in providing an experiential aspect of the service )
  - Patients can sign up to be a private patient, and if they are not happy, it is possible for them to switch back to being a Medicare patient;
  - That is, information should also be made known to patients that the commitment of using PHI is an obligation-free arrangement, and patients are able to opt-out from using their PHI at any time.
- Opportunity to ask knowledgeable employees for information regarding financial choice and answer questions related to the election process



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- By having knowledgeable staff (PPO), the health service provider (the hospital) can advise patients on financial elections and answer patient enquiries and greatly reduce the patients' fear of unknown risk (PHI election);
  - Health service providers such as clinicians, nurses and doctors directing patients' enquiries to the appropriate people so as not to discourage the use of PHI can work positively in facilitating patients' election of using PHI.

### **Methods that service providers can use to reduce perceived risks**

- Offer a free trial for services with high-experience attributes (for example, a trial of piano lessons usually works quite well in reducing consumer's perceived uncertainties as consumer are not sure the quality of service)
  - For PHI in the healthcare setting, the hospital provides no OOP expense guarantees; this is equivalent to a free service trial, as patients will not be expected to pay anything to experience being a private patient and to receive benefits as a private patient.
- Advertising and promotional material to help with visualisation, making the service experience/result a more tangible prospect
  - Visual aids are helpful in communicating ideas and concepts to people in the case of matters that are difficult to grasp. There are many ways in which these concepts could be delivered visually. However, in a healthcare setting for PHI, it could be argued that the results of what PHI benefits could be brought to the patient, to the community or to the hospital, is of particular relevance to the patients themselves. For example, if a patient utilising his or her PHI in a public hospital was told

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that “using PHI greatly helps the hospital in continuing to provide the excellent care to the patients,” such altruistic reasons would be seen by the patient as relevant. To further demonstrate the relevance, the organisation promoting the PHI could choose to show how the contribution from PHI funds have assisted the hospital and its surrounding community in terms of funding new equipment, the addition of new wards, employment of new technology, etc.

- Displaying credentials or offering guarantees (e.g. “your problems will be solved or your money back”) reduces psychological risk for consumers
  - By providing written guarantees to patients that they would incur no OOP expenses, and that there are people who could assist them with their enquiries, reduces the amount of anxiety and uncertainties that patients are likely to experience.
- Use evidence management (quality service is usually associated with professionalism and credentials)
  - In an result reporting and analysis chapter of this thesis, results from the empirical study indicate that more than 25% of the respondents did not think that the staff who provided information to them about PHI appeared to have a good understanding of PHI products;
  - It is important that staff representing the hospital who provide advice on PHI-related matters are knowledgeable, approachable and friendly;
  - In addition, staff are offering patients with quality service, that the staff have a thorough understanding of PHI-related issues and that their advice is trustworthy.

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## **Encouraging PHI utilisation and its association with customer service quality**

Some scholars have associated service delivery with marketing principals and the consumer decision-making process. This has also been alluded to in the literature review chapter, Manner (2009) suggests that decision theory in economics and psychology is concerned with identifying the values, uncertainties and other issues relevant in a given decision, its rationality, and the resulting optimal decision. Manner (2009) referred the term decision theory with a strong focus on value and it is understandable that if a service is perceived to be good then there is value associated with it. There are several attributes from a service-marketing perspective that would assist with promoting services to potential consumers. These attributes are broadly described as reliability, assurance, tangibility, empathy and responsiveness, they are sometimes referred to as the RATER model in customer service (Buttle, 1996). This chapter describes the relationship between encouraging PHI utilisation in a public hospital, and how attributes of both the service and promotional strategies interact with each other.

Reliability, in this context, refers to the ability to perform the service dependably and accurately. To a hospital patient, it may not be easy to separate the association of quality of healthcare and the willingness to convert to being a private patient. For health-service providers, by delivering the service as promised (good clinical care, no OOP expenses, and the provision of benefits, all exactly as described) which match the patients' expectations then the service is considered good. Consumers' needs and wants for services are often that they should be delivered timely, consistent, accurate, and dependable.

Hospital employees' knowledge, professionalism, courtesy and their ability to inspire trust and confidence can offer assurance to patients. It is not difficult to see why the

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PHI issue is much broader than it merely being one of the ways of meeting the cost of providing healthcare to the population, but also a means to instil trust in employees and patients. Staff with the right knowledge and skills to deliver the services as promised and provide detailed and accurate information about PHI shows that the health-service provider is trustworthy and dependable.

Another aspect, tangibility refers to the appearance of physical facilities, equipment, personnel and communication materials. Physical feel of the facilities, equipment, appearance of employees, and communication materials should appear appropriate. Appropriate uniforms can convey staff professionalism. Indeed, public hospitals feel different from their private counterparts, as public hospitals service the whole population, not just a select minority. Patients who use their PHI are usually told that they assist the hospital and their local community. However, on top of these altruistic benefits, many patients would also like to enjoy some more tangible, more personal benefits as a result of using their PHI, and therefore a variation of tangible service offerings from usual public patients allow private patients to see value in them going private instead of going public. It should be noted that by using PHI in a public hospital, it does not in any way vary the quality of clinical care patients would receive; however, the peripheral benefits that private patients gain by helping the hospital could be seen as a way for the hospital to thank these private patients.

Individualised attention provided by PPOs to patients in answering their individual PHI-related queries refers to the aspect of empathy in customer service. Patients and other staff should be able to easily access PPOs, and should be able to obtain prompt service and have their problems resolved/questions answered quickly and smoothly. Furthermore, empathy and courtesy should also be embedded through the

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care and assistance offered to patients by all hospital staff; their helpful actions and empathy provide patients with a sense of contentment and reassurance.

One of the last aspects in customer service refers to responsiveness. In the context of PHI utilisation, responsiveness means that staff working for the health service provider, especially PPOs, should show strong willingness to help patients, provide prompt service and resolve problems satisfactorily. By delivering services in such a manner, the healthcare provider can demonstrate a level of customer service that can satisfy the patients' needs and wants. It is commonly believed that people make decisions based on rational analysis of effort, cost and potential benefits of a particular situation.

An emerging school of thought on behaviour science/economics has argued that people are not always rational when making decisions relating to financial matters (Sadi et al, 2011). One of the aspects of this theory asserts that people purchase products merely to satisfy a psychological need. When this thought is applied to the topic of using PHI, it could be understood that people who come to a public hospital have a psychological need to receive a cure for their illness; the decision about whether or not to use PHI is peripheral, and may not always be rationally understood, even by the patients themselves. For example, for a patient who decides not to use their PHI cover in a public hospital due to fear of OOP expenses, even after it was guaranteed that there would be none, an irrational decision is probably made because they do not trust the public health system, or because they had a general lack of understanding of it. However, on the other hand, if trust in the public health system is an issue, the patient's perceived better alternative choice to not go to a private hospital could also indicate an irrational decision.

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From another perspective, people may perceive that when they use PHI they will receive better-quality care, as they paid the insurance claim (in turn benefiting the health-service provider). An opposite interpretation of this argument could be that public patients who rely on the public Medicare system were all receiving inferior quality of healthcare. Indeed, when such an argument is presented, many could argue against it as it is obviously flawed as generally patients in Australian public hospitals receive good, high quality care. However, this is indicative of the problem of people not always acting rationally or making rational decisions. There appears to be numerous factors that could potentially interfere with patients' decision-making processes, and ultimately influence the end result.

In addition, there is another type of private patient who is admitted to a public hospital under a private self-funded arrangement with a doctor of their choice. Put simply, a patient who is "self-funded" is not a member of any PHI cover, but is eligible for Medicare; the patient chooses to pay for the service provided by that particular doctor, as that is their own preferred doctor. A patient has to pay for the privilege of choosing their own doctor, and this is a private arrangement between the doctor and the patient. These patients may have used some form of financial rationality to work out the opportunity cost of purchasing PHI versus funding the private arrangement only when needed. However, such a decision could be based on the subjective judgement of their own health conditions, their own personal preference toward that particular doctor, and/or genuine financial difficulty in not being able to afford the PHI monthly premium. Finally, other reasons for patients choosing not to use the insurance could be due to their level of PHI-product cover (e.g. ancillary cover only, no hospital cover), or the waiting period restrictions disallowing them from using the cover.

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In summary, the literature search found a vast array of articles encompassing the choice of PHI purchase, and a small minority of literature discussing several points on using PHI in general. The decision to purchase and decision to use is influenced by a number of factors; it has also been found, however, that sometimes these decisions may not have been made rationally, due to the very nature of human irrationality theory (Kiyilar & Acar, 2009).

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## **5. PHI utilisation and its impact on individuals and hospitals**

Public hospitals in NSW are usually given annual financial targets in terms of expenditure and revenue budgets. Patient fees are often the biggest components forming these revenue budgets. In the previous chapter, a range of literature regarding reasons why people purchase PHI and why they might choose to use PHI in a public hospital was examined. This chapter covers a literature search on the topic of benefits to patients of using PHI in a public hospital, and the financial impact to the hospital. This chapter also explores the relationship between PHI utilisation in public hospitals and the revenue targets that public hospitals are required to meet every year.

As discussed briefly in the previous chapter while reviewing the PHI utilisation in a public hospital, there are several points of entry to public hospitals in NSW. Generally, when patients are first registered on the hospital patient registration system, they are requested to provide information about their financial status and whether or not they hold PHI. When the holders of PHI are identified and are admitted as inpatients, they are given the option to choose whether or not they would like to use their PHI for this admission. During their stays and even after discharge, patients can still elect to be private patients.

### **5.1. Benefits To Patients Of Using PHI In A Public Hospital**

Depending on the type of PHI policy, there are certain conditions that may financially affect the insured party. For example, there is usually an excess that the insured party has to pay before the PHI will cover the rest, however, there are also products that do not require an excess payment. Some OOP expenses, such as the doctor's



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fees, are not fully covered by PHI. In addition, under limited circumstances, certain pre-existing conditions and waiting periods have to be eliminated/served before the insurance company will provide cover. In general, people who bought PHI cover have consciously committed financially and generally understand what the cover could be used for.

As mentioned briefly before, PHI in Australia is highly regulated by the Federal Government, and the insurance premium is set based on community rating rather than claim history (Buchmueller et al., 2009); Community rating means that everyone is entitled to purchase PHI, the health funds cannot refuse to insure an individual based on the purchaser's health or claim history. Also, it is not necessary to charge any premium penalties for using the insurance (a different price structure to that of car insurance, whereby a user has to pay a higher premium if they have previously claimed for an accident). This means that there is no additional financial impact to PHI holders for using PHI for their hospital stays, apart from the insurance premium that they have already paid.

A study conducted by Sullivan, Redpath and O'Donnell (2002) in a Victorian public hospital discovered that approximately 20% of patients admitted to the hospital never intended to use their PHI, even though they held PHI cover. This study was a quantitative study based on primary research data collected in a hospital survey, together with a qualitative pilot study aimed at understanding the reasons as to why patients chose not to use their PHI. This study was relevant in exploring the impact on patients and the hospital in patients' choice to use PHI.

Sullivan, Redpath and O'Donnell (2002) identified that there were potential benefits and disincentives within the public health system that would influence patients' decision about whether or not to use their PHI. Furthermore, it was noted that there

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was a correlation between the level of knowledge about PHI products and the decision about whether or not to use PHI (Hindle & McAuley, 2004). An assumption in this article stated that some patients may have taken out minimum health insurance policies to avoid higher tax, and were still relying on Medicare. In previous sections, a number of empirical studies based on the 2004-2005NHS have proved this assumption valid, and many patients indeed took out the cover for the very purpose of avoiding higher tax. One guiding principle in people's decision about whether or not to take out PHI cover is often driven by the belief that it will save them money from a tax perspective (Richardson & Segal, 2004). Similarly, once a PHI holder goes to a public hospital, either through the booked-elective admission corridor or through the unplanned emergency corridor, the impact of them choosing whether or not to use PHI would be based on the understanding of whether or not additional financial commitment is required (referring to excess, gap payment or another co-payment), and some consideration of additional effort required of using PHI may also be when compared with being a public Medicare patient. This assumption is also useful in helping to understanding how to increase the patients' knowledge of the PHI product and make them better-informed about whether or not they would like to use their PHI cover in a public hospital.

In Sullivan, Redpath and O'Donnell's (2002) study, hospitals would need to provide benefits such as a free television/telephone, and priority access to single rooms in order to attract patients to use their PHI. The study noted that some patients found these material items to be worthwhile benefits. These benefits provided an incentive to patients to elect to use their PHI cover, to whom these items are seen as providing added value. The study did not quantify the exact monetary value these benefits would be accounted for to the patients. One could reasonably assume that because patients would have to pay for these extras if they were to be treated as a public

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patient, the financial benefit obtained by the patient equates to exactly what it would have otherwise cost them. On the other hand, only patients who used their PHI cover are given such benefits, the study argued that such differentiation provides patients with a sense of worth when it comes to using their PHI cover.

Nevertheless, the study by Sullivan, Redpath and O'Donnell (2002) had many drawbacks that could have affected its generalisability and accuracy. It has been noted that the researchers of this study utilised a questionnaire on day of surgery admission (DOSA) on a sample size of 200 patients. The study spanned across 2 months with selected days instead of a period of longer time that increased randomness in sample selection, and the sample used (DOSA) was elective patients only. It should be noted that this study had not included patients who have entered via the ED or any other means. This meant that the study focus was not balanced because it did not represent the entire hospital's admitted population. In addition, the sample size may not have been large enough to be representative, therefore the findings were unlikely to be very valid if generalised to a larger population. Furthermore, this study was conducted almost 12 years ago based on a hospital in Victoria, the timeliness and relevance of the findings may be poor when compared to the current situation, and could therefore be unreliable when applied to today's NSW public hospitals.

## **5.2. Benefits To The Public Hospitals Of Encouraging People To Use PHI For Admission**

Public-hospital budget control presents enormous challenges in the environment of ever-increasing healthcare expenditure. In earlier sections of this thesis, the multifactorial impact of advancement in health technology, increase in the public's expectation and increase in the cost of labour, together with an increase in the

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population's life expectancy, means that the cost of providing healthcare services is likely to continue to increase in the foreseeable future (Seshamani & Gray, 2002). Some have estimated that, should the health expenditure be not appropriately controlled in the state of NSW alone, it is likely to consume the whole state's budget in the year 2033 (Gadiel & Sammut, 2012). Indeed, the state budget will be increasing due to inflation and a range of other reasons, however, such projected extrapolation is indicative of the type of fiscal challenges facing the Australian State and Federal Governments now and in the near future. This is why revenue raising has become an important component of hospital budget control, and as such, it is also important to understand the costs and benefits involved in encouraging patients to use PHI.

Hindle and McAuley (2004), through their archival study, attempted to explain the effects of increased PHI based on evidence gathered during the PHI policy development. This study took an international macro-economic perspective on the overall impact of increased PHI coverage and its relationship to the service cost of the public and private health sectors, health service provision, population's access to care, etc. It did not examine further, at a micro-economic level, the way in which individual public hospitals will be affected financially.

Sullivan, Redpath and O'Donnell's (2002) study suggested that material benefits such as free television/telephone hire, better food and single rooms were tangible benefits that the patients see as valuable and could provide patients with enough attraction for them to use PHI. However, the paper arbitrarily assumed that the cost of providing these "extras" was prohibitive, and that the costs involved would not see a commensurate increase in patients using their PHI with any actual or projected financial implication analysis.

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In addition, the researchers of this thesis failed to clarify or define what prohibitive cost means from their perspective, and there is a lack of measure in arguing at what point the cost of providing these benefits becomes not worthwhile to pursue.

On the other hand, it can be seen that the assumption that it is not worthwhile in providing “extras” to patients was made without any concrete evidence and analysis; it cannot convince academics who would require empirical evidence to make an informed decision on the validity of their argument. In addition, in the bid to encourage hospital patients to use their PHI cover for a hospital stay, hospitals often choose to waive the patient’s excess or negotiate with the doctors to also waive their gap fees. There are other costs associated with encouraging patients to use PHI, such as administrative time and creating and distributing communication materials to encourage patients to use their PHI cover. The cost for some of these intangible services provided aimed at converting patients from public to private has not been properly quantified in Sullivan, Redpath and O’Donnell’s study. The biggest cost involved in encouraging patients to use their PHI is perhaps the cost of waiving the PHI policy excess for patients, in order to counteract their fear of OOP expenses. Waiver of excess is often done for patients who are admitted via the hospital ED, the rationale being that this can increase patient’s rate of electing to use their PHI, with the resulting additional revenue generated through patients using that PHI far exceeding the cost of waiving the fees. However, it appears that there is a lack of empirical study in appropriately accounting for the cost of waiving the excess and quantifying the effectiveness of such an initiative from an academic sense; Sullivan, Redpath and O’Donnell’s (2002) study also lacked such measurement.

There have been bodies of literature encompassing the financial implications on the public health system of people choosing to use PHI due to the policy changes.

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Literature examined in the previous sections of this study largely looked at whether or not the historical policy changes have been able to increase the amount of population buying PHI to alleviate the pressure on public health funding, as seen above. However, no literature analysing the financial costs and benefits of encouraging patients to use PHI in a public hospital has been found. It appears that a study should be conducted in this area to increase the understanding of these financial costs and benefits. Importantly, public hospitals should be accountable for the funds spent on encouraging more patients to use PHI, and should understand whether or not these expenditures are indeed cost effective. In addition, a study on this topic is useful when it comes to designing cost-effective future programs to encourage more patients to use PHI in a public hospital.

Moorin & Holman (2006) posited that when the attrition rate of PHI holders grew between 1991 and 1996, the number of private patients in the public hospital reduced; this is especially true in the low socio-economic group. This phenomenon could lead to a reduction in public hospital revenue. Duckett (2005b) suggested that PHI policy development in the late 1990s encouraged people who would normally receive care at a public hospital to change to a private hospital. His argument focused on the fact that the shifting of the health service burden from the public sector to the private sector is a consequence of the policy change, and the approximate cost is \$12,500 per patient. It is unclear as to whether the assumptions made were based on any pre-tested financial analysis, or whether the actual savings could be verified. Based on Duckett's (2005b) argument, public hospitals could be affected in 2 ways under the PHI market back then: on one hand, in that more patients would choose to be treated in a private hospital than in a public hospital, and the public hospital would lose the revenue it would have gained by treating private patients; on the other hand, there is a cost saving for public hospitals

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associated with patients choosing to be treated in private hospitals instead. Amid these assumptions, a shift of cost from public hospitals to private hospitals may not be easily quantifiable, and the lost revenue may not be easily accountable. This is because the issue of patients moving from the public health sector to the private health sector does not equal a reduction in workload in the public sector; it simply means that extra availability was made possible in the public sector for dealing with other cases, and this availability would soon be filled up by the existing healthcare demand.

Referring to a survey mentioned previously, the result of people not using their PHI in public hospitals was shown in the 2004–2005 NHS, where nearly 20% of those who had a PHI and were admitted to public hospitals chose to be treated as public patients at their most recent hospital visit. By understanding the cost of encouraging patients to use their PHI cover for a public hospital stay, health managers will in turn gain an understanding what predicted costs would be involved in converting these patients from public to private.

### **5.3. Alternative Views On Private Patients In Public Hospitals**

A study sponsored by the Australian Health Service Alliance (AHSA) and the Australian Centre for Health Research (ACHR) was published in April 2013. AHSA is a company that represents registered private health funds across Australia. The ACHR was initially established by the private health fund, Australian Unity; it is an incorporated company entity with most of its board members having associations with PHI funds. King's (2013) paper highlighted the increased drive by public hospitals to increase the number of private patients, and that a large amount of increased revenue was achieved through this. The paper criticised that public hospitals, through the encouragement of the State Government, have proactively

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marketed to their captive audience of vulnerable people who have fallen ill and been admitted to the hospital. King (2013) further argued that the public hospitals are using staff and facilities funded by tax-payers to raise money in direct competition with privately funded facilities, of considerable concerns are facilities such as private hospitals and private radiology practices.

King put forward a number of recommendations to amend the National Healthcare Agreement and the National Health Reform Agreement so that it would make it harder for public hospitals to convert public patients to private and thus restrict patients from having a real choice in their financial elections. It appears that the paper very much disagrees with the current arrangement whereby patients with PHI coming to public hospitals can choose whether or not to use their PHI.

On one hand, King (2013) assumes that it is incorrect to convince patients to use their PHI just because they have purchased PHI. King strongly argues that people purchase PHI because they would like to have choice; however, no referral is made to any empirical study results around why, statistically, people choose to purchase insurance. In fact, empirical study statistics may have argued quite differently as to why some people have purchased insurance. Furthermore, the paper's assumption that Medicare treatment is the default financial election for every Australian may not be correct, as the National Healthcare Agreement does not preclude a privately insured patient from using PHI for their public hospital admission. While the National Healthcare Agreement intends for patients to have a choice about their financial elections, without providing information to patients about using their PHI and assuming that every patient is a Medicare patient by default, this does to some extent deprive patients of that opportunity to make their financial elections.



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King's paper also claims that NSW public hospitals put pressure on doctors (VMOs in particular) to admit private patients, promising them immediate access to the hospital in preference to public patients. It is not clear where such evidence derives from. It is commonly understood that doctors/clinicians would often make judgements based on a patient's clinical condition to decide whether the patient is in need of priority treatment. VMOs who work on a contractual basis in public hospitals usually also work in private practices and/or in private hospitals. Compared to admitting a patient to a public hospital a VMO enjoys higher flexibility when charging patients in a private hospital. Also, due to high level of service demand at public hospitals, it is unlikely that a patient is able to queue jump surgery waitlist because they are private. In addition, public hospitals have strict patient waitlist policies where patient waitlist placement is based on patient's clinical priority rather than clinical preference.

It should be noted that the study is sponsored by two important research and advisory bodies in the PHI arena; the amount of profit that may be eroded by public patients choosing to use their PHI may have prompted the need for this research to be conducted. However, some fundamental questions that the paper fails to address is: who would benefit financially if people purchase PHI but do not use it?; and where would the extra funding be coming from when the pressure on the nation's health system reached a critical point?

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## 6. Literature Gaps & Research Questions

Upon examination of the literature in the previous two chapters, a number of common themes could be identified.

- (1) As a remedy to the problems of the MBS, the Australian Federal Government devised various ways to increase the population's uptake of PHI. These policy instruments were effective in increasing the uptake of PHI among the population in the late 1990s and early 2000s.
- (2) There appeared to be a disconnect between the intent of these government policies and the outcomes that followed. Specifically, a large portion of people holding PHI were still relying on the MBS instead of using PHI and/or being treated as private patients.
- (3) The decision to purchase PHI and the decision to use PHI in a public hospital has some relationship; however, the decision process involves many steps and can be influenced by multiple factors.
- (4) There is general support from the population of the universal free public healthcare system over the private pay for service private healthcare.
- (5) Patient's choice of using PHI can financially impact both themselves and the healthcare facility they are staying at.

This chapter aims to examine the gaps identified through the literature review and explore how this thesis attempt to address some these gaps through primary research in understanding the influencing factors in patient utilisation of PHI in public hospitals and what impact this has on patients using PHI. Lastly, this chapter would pull together the knowledge gap and specify the research question for this research.

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The study commissioned by the Australian Institute of Health and Welfare (2008) and figures released by PHIAC (2010) both presented the common theme that PHI funding accounts for a relatively significant portion of the total healthcare expenditure, and that a significant population hold PHI. A large number of studies focuses on discussing the changes of PHI enrolment as a result of PHI policy development between the late 1990s to the early 2000s. For example, Munn and Wozniak (2007), Sundararajan et al. (2004) assessed the effectiveness of the policy in increasing PHI enrolment, and concluded that the lifetime care and income tax threshold were important in increasing the uptake of PHI cover.

When analysing the literature pertaining to the topic of factors influencing patients' decisions about using PHI, a number of studies based their analysis on data obtained from the National Health Survey (Buchmueller et al., 2009; Srivastava and Zhao, 2008). Although there were slightly different methods to how these scholars analysed the data, common conclusions were that about 20% of those who had PHI and were admitted to public hospitals public chose to be treated as public patients at their most recent hospital visit. This finding has an important meaning; it calls for additional studies to be conducted in order to understand why it is that a significant number of patients would still opt to be treated as a public patient than be treated as a private patient (either in a public hospital or in a private hospital). When health resources are finite, healthcare service providers are required to find innovative methods to fund the way that care is provided, and revenue raising or cost recovery is one of them. Understanding what factors shape patients' decisions on whether or not to use PHI in a public hospital paves the way for a more sustainable and holistic healthcare system.

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## 6.1. Inconsistencies Between Literature

During the literature search, it has also been found that there are inconsistencies in some study findings:

- Hardie and Critchley (2008) presented a study result that the public generally placed more trust in private hospital than public hospitals. Natalier & Willis (2008) argued that this not so clear-cut, and that it depends on the individual's perception and their experience with the service. These results are important to help gain an understanding the public's perception of both private and public healthcare services, and its intrinsic relationship with patients' decisions about whether or not to use PHI.
- Depending on the timing and data source, the way the assumptions and parameters were made in some of these studies appeared to contain some discrepancies on information, such as what proportion of the Australian healthcare is funded privately, and why patients choose to access public healthcare even though they hold PHI cover. The latter issue raises many questions over the purpose of consumers even purchasing PHI if they are not using it, as well as those about who these purchases are ultimately benefiting.
- Srivastava & Zhao (2008) mentioned the nature of adverse selection of PHI, while Buchmueller et al. (2009) argued against adverse selection, instead pointing out that health-conscious people were involved in advantage selection. In some of these discussions, adverse selection often means that people who have the need to avail themselves of the health service due to poor health are more likely to remain insured, while people who are healthier tend to drop off from health funds, making the majority of the insured population a burdensome population for the insurance industry. This then

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ultimately causes a rise in insurance premiums, resulting in a reduction in the insured population (Gans & King, 2003). Advantage selection, on the other hand, refers to people who see the advantage of being insured and thus purchase a PHI policy in order to be part of the insured population.

Both arguments seem to have some validity, depending on the context in which the topic was examined. In relation to PHI utilisation, both viewpoints need to be examined equally on their contribution to the topic.

On the topic of using PHI, Shiell and Seymour (2002) found that individuals may be motivated by not only the factors that may satisfy their own preference, but also by the sense of contribution to the general good of the community/society as they are helping the public hospitals in meeting its service and funding demand. This argument is different from that of Srivastava and Zhao (2008), who specifically assume that individuals take out PHI cover largely only based on potential benefits to themselves. The fact that the latter theory has many supporters does not make it more valid than a theory with fewer supporters that emphasises the importance of individuals' altruistic view of PHI and the public healthcare system in general. Although there are merits on both sides of the argument, it should be noted that an unbiased scholar's view ought to weigh up both arguments and consider their validity based on empirical evidence.

In the previous chapter on decision theories, it has been noted that Ariely's (2008) theory on predictable irrationality argues that people's decisions about purchasing products is inherently irrational. Natalier & Willis (2008) assert that people do not go through a calculated reasoning system when evaluating a decision about purchasing insurance, and that there are correlations between the irrationality of decision-making and human inconsistency. Although this may make the topic of factors

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influencing PHI utilisation seem trivial, it does provide a unique perspective in viewing the decision-making process with a humanistic element.

An analysis conducted by Apps, Rees and Wood (2007) is also distinctive as it focuses on household survey data to show that female labour supply is strongly positively associated with household saving and the purchase of PHI and general expenditure on family health. It was unable to locate another study that replicated the findings by Apps, Rees and Wood (2007), and the reliability and scope of future application of this study is therefore unknown. However, one important indication from this study is that an increased amount of disposable income sometimes represents the ability and willingness to be covered by PHI insurance cover. Assuming a large percentage of population is covered by PHI due to high income, it is likely that lower level of income could mean that a relatively lower number of insured patients visit public hospitals, and thus the utilisation of the total number of patients could be lower.

## **6.2. Controversial Issues In This Topic Area**

Perhaps the debate of private healthcare versus Medicare has always existed ever since the introduction of Medicare in 1984. As Hardie & Critchley (2008) point out, there is a low level of endorsement to the user-pay private healthcare provision model, and instead universal public funded healthcare is more widely favoured. However, one could argue that the public's way of thinking about and assessing the state of the healthcare system is subjective and it is not objectively based on actual financial expenditure from a responsible fiscal management point of view. That is, although controversial, the public is generally not appreciative of the level of funding and service demand pressure that the public healthcare system faces. The controversial nature of this issue could mean that a portion of the public may be

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against the idea of using PHI in public hospitals because they do not think it is the “right” thing to do, believing instead in only free universal healthcare in public hospitals.

Another controversial topic is the discussion surrounding the effectiveness of the government PHI policy changes in alleviating the pressure on public hospitals (Duckett, 2005a; Walker et al. 2007; Srivastava & Zhao, 2008). Generally, some argue that the PHI policy changes successfully shifted public patients to the private sector (Shamsullah, 2011); some argue that the policies were ineffective in alleviating the service demand pressures on public hospitals due to a lack of well-planned policy objectives (Carter & Chapman, 2001). Regardless of the rights or wrongs of each argument, the controversial nature of this issue raises questions about what financial impact exactly the policies would have at a local-hospital level if there were to be a change in the percentage of private patients in public hospitals. Further, the costs are involved when public hospitals are required to meet their revenue targets. No empirical studies that attempted to uncover these issues were found during the literature search.

### **6.3. Gaps In The Relevant Study**

In the previous chapter on decision theories, a study by Sullivan, Redpath and O'Donnell (2002) was described as focusing on PHI utilisation at a hospital-operational level. Some valid findings and conclusions are drawn in this study, specifically relating to the primary research conducted around the reasons as to why patients chosen whether or not to use PHI in a public healthcare facility. It discusses the importance of benefits and disincentives that affect patients' decision making process. In general, the study is clear and relatively easy to follow. It avoids using technical jargon and uses grammar that is easy for readers to comprehend. The

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format of the paper is clear and readable, with sub-headings and linking sentences. The authors use tables to present the findings, making it easy to follow. There is a reasonable link between the research question and the study's methodology. The conclusion refers back to the research question to answer the initial question.

However, this study is not without its shortcomings. Firstly, the study was conducted in 2001; its relevance to the current PHI development in Australia may still have validity, however, any recent developments in the area of PHI may affect the generalisability of this study. The survey study takes a representative sample of an unknown size and designs the questionnaire for this survey based on an earlier pilot study. Little detail is provided about this pilot study in order to examine the reliability of the variables used. No sample questionnaire is provided in order to allow an examination of whether or not the question design is biased. There is also a lack of information about how the researchers have selected the study's sample patients. One could argue that without these essential pieces of information, scholars are unable to verify or confirm the reliability and appropriateness of the study tool.

Additionally, an assumption made about the study sample was that since the patients were admitted as public patients, they must not have elected to use PHI. This may not be entirely true, because people with waiting periods on their PHI policies are not strictly classified as such, and did not elect not to use PHI, rather, they were merely prevented from doing so due to policy restrictions. On the other hand, self-funded patients who are not covered by a health fund are not normally strictly classified as private patients, as they occur infrequently and are not considered to be part of the PHI study subject.

Moreover, the authors present some brief comments regarding why patients took out PHI, without referring to any empirical studies to confirm these assumptions. In



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addition to this, the study automatically indicates in the survey result that 30% of patients with PHI had intended to use their PHI but were not given the opportunity to do so. Little information about the reliability of the derived percentage is made available; there is inadequate elaboration on what is meant by “missed opportunities” and how/why some patients were unable to elect to be private patients. Questions should be raised about these points, as they are critical to the central themes of the study.

Furthermore, the paper recommends several ways to improve the PHI utilisation rate in public hospitals without incorporating a detailed analysis of the effectiveness of these methods. This study draws reference to the importance of raising hospital revenue as the key to meeting hospital operating budgets without recognising the need to also identify the cost of doing so, which would likely to impact both patients and public hospitals.

Finally, this thesis presents its findings only briefly, drawing conclusions rapidly without a detailed enough exploration of the results of the study. While it is unlikely that any study is going to be free of shortcomings, Sullivan, Redpath and O'Donnell's (2002) study, however, did not appear to contain a recommendation of how the study could be improved in order to overcome some of its potential shortcomings, indicating that the scholars did not take a critical view of their own work.

There are a number of broad assumptions that Sullivan, Redpath and O'Donnell (2002) adopt in their literature search on the topic of purchasing and using PHI. It has been generally assumed that people who buy PHI make the decision rationally, and the decision of whether or not to use the PHI once admitted to a public hospital is also rational. Furthermore, it is assumed that people have good understanding of their chosen PHI product, and that they chose whether or not to use their PHI based

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on that understanding. These assumptions are fundamentally flawed. Firstly, Ariely's study (2008) reveals that people do not make rational decisions, especially when it comes to financial issues, and that the reasoning behind why people purchase PHI products does not always determine the reasoning behind why they would or would not use their PHI policy. Because the decision-making process from initially purchasing PHI to actually using it in a public hospital involves many complex steps and factors, all these steps and factors would affect the ability of people to make a clear and rational decision. Furthermore, the assumptions do not take into consideration people's interactions with individual health-service providers; their opinions, judgement and recommendations to patients could have a profound impact on those patients' decision about whether or not to use PHI. In addition to the patient's perception of public healthcare, the type of care they actually receive when in hospital, as well as the patient's interaction with staff and fellow patients, can again have impact on the decision about using PHI.

Factors such as a patient's geographical convenience to the local hospital (public or private); knowledge of services provided at the local hospital; familiarity with the local amenities; and whether or not they have had previous positive contact with the public health service could also play an important part in influencing a person's decision to use PHI in a public hospital. The studies examined have not taken into account the effects of these factors. Factors such as these are not thoroughly explored in the studies found, indicating gaps in the literature.

It is evident that the existing bodies of literature neither attempt to address the problems of these flawed assumptions, nor examine the process of receiving healthcare in public hospitals. Currently, there is a lack of systemic and empirical study into and thus a lack of understanding of the decision-making process of those

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with PHI and their interaction with the public hospital system. These factors warrant further study in order to determine the reasons behind patients' decision about whether or not to use PHI in a public hospital.

Furthermore, it should be noted that the literature search found no papers that discuss in any depth the financial impact of PHI utilisation for public hospitals, or the cost of converting public patients to using their PHI. There may be the broad assumption that there is financial advantage in doing so, however, no concrete financial evidence exists to demonstrate such claim. This lack of knowledge shows a vast gap in this topic area, and this thesis attempts to bridge that gap.

#### **6.4. Research Questions**

Based on the analysis of a range of literature, there appears to be large gaps in the understanding of what drives patients' decisions about whether or not to use PHI in public hospitals. There is also a lack of understanding of what the financial implications of PHI use are to the individual patient and the public hospital. In addition, given that revenue raising is a critical performance indicator of public hospitals in NSW, there is the need to identify how patient-fee revenue could be increased through increasing PHI capture rate.

The research question derived in this study would attempt to provide additional knowledge in the areas of motivation for using PHI and financial decision making in a hospital setting. The research questions are as follows: what are the factors that influence a patient's utilisation of PHI in a public hospital? What is the impact on individuals and public hospitals of using PHI?

In summary, a review of the literature on the topic of PHI prompted the need to investigate matters surrounding PHI utilisation in a public-hospital setting. This new

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research topic is important to public hospitals in helping them gain an understanding of why some patients choose not to use PHI in a public hospital, as well as consider more effective strategies to encourage more patients to use their PHI. In addition, the study will also provide insight to the reasons as to why patients choose to purchase PHI in the first place, aiming to obtain an understanding of their psychological decision-making process. Lastly, the study will reveal the financial implications for public hospitals in encouraging more patients to use PHI to determine the effectiveness of current practices, and provide guidance for strategies in the future.

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## 7. Method

This chapter's central theme focuses on the method of research. It goes in detail to describe how the method was selected and used as well as what considerations were taken into account when deciding on the methods including piloting of the instrument. This chapter also documented the procedures of how the research was carried out, which constraints, assumptions and possible limitations of the method.

### 7.1. Research Questions

A range of issues concerning the topic of PHI utilisation were discussed in previous sections. The research aims to address a number of these key issues through the following research questions.

What are the factors that influence a patient's utilisation of PHI in a public hospital? What is the impact on individuals and public hospitals of using PHI? Throughout the literature search it has been found that there were anecdotal explanations of the phenomenon that a portion of admitted patients who hold a PHI policy choose not to use it in public hospitals. There appears to be a general lack of empirical study and understanding of the reasons as to why patients chose to use or not use their PHI cover in a public hospital. When public hospitals need to focus on revenue raising as an important initiative to manage finite financial resources, they should be able to look to this study to discover the key initiatives that should be undertaken to achieve that goal. It would most likely to be conducted through a study of people's choices and decision-making process, using some form of survey or census.

Studies into cost and benefits of using PHI in public hospitals are often conducted at a macroeconomic level, and the discussion focuses on policy outcomes and the predicted shift in the healthcare burden for the whole nation (Brameld, et al, 2006).

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There appears to be a lack of empirical evidence relating to what patients' PHI election actually means financially to the hospital. This means that the actual cost of patients using PHI and gains for the hospital are not determined in a scientific way.

## **7.2. Research Method Justification**

Several research methods are employed in this new research in answering the three key research questions. Firstly, in order to understand what factors influence patients' decisions about whether or not to use PHI in a public hospital, a survey is conducted with patients to capture first-hand data around their decision-making process. This proposed study is concerned with inpatients who are admitted to a hospital, the studies exclude any patients who visit the hospital but are not admitted (i.e. outpatients).

There are four public hospitals (Balmain Hospital, Canterbury Hospital, Concord Hospital and Royal Prince Alfred Hospital) within SLHD and more than 220 public hospitals and health services in NSW. It is not realistic to conduct such research on every public hospital within NSW, nor is it feasible to conduct the research on all four hospitals within the SLHD, due to the amount of patients that would be involved, and resources that would consequently be required. This research was conducted at Canterbury Hospital as an exemplar. Case method or case-study method is an empirical inquiry that investigates phenomenon within a real-life context; data would usually come from archival records, interviews, direct observations, documentation, physical artefacts and participant observations (Yin, 1994). At a hospital level, a typical survey focuses on a sample and tries to generalise the study findings to the broader population. The study of a subset of a population maybe cheaper and easier, and if done right could obtain the same results as a census. However, there is the chance of lost data-fidelity in selecting and stratifying samples (Fraenkel & Wallen,

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1996). Even though at times, sample based-study is the only way to collect data, a number of factors still need to be considered for determining the appropriate sample size: the level of precision, the level of confidence or risk, and the degree of variability in the attributes being measured (Miaoulis & Michener, 1976). It is evident that the combination of these conditions is likely to add to the complexity of a study involving samples. Additionally, the data sampling, if not appropriately selected, could be open to bias, inaccuracy and/or poor generalisability.

It is due to the combination of these reasons that a decision was made to survey the entire inpatient population of one hospital where possible, so to maximise the number of relevant respondents and thus improve inaccuracy and generalisability. The study collects a range of both quantitative and qualitative data, focusing on the research questions, which requires multi-level perspectives and real-life contextual understanding regarding the decision-making and processes for PHI utilisation.

Based on the discussions above regarding research methods, it is most appropriate that a case method be employed in this study for one hospital only. Canterbury Hospital, an entity within the former Sydney South-West Area Health Service and the current SLHD, has been selected as the case study subject due to its relatively large bed numbers (220 inpatient beds) and the representation of a typical SLHD population group (the Canterbury LGA is ethnically diverse). In addition to this, the researcher has experience of working with staff at Canterbury Hospital, and is familiar with the hospital's procedures and processes employed in capturing more patients with PHI. Furthermore, the data that will be used for the financial modelling can be obtained through the Area Health Service's financial information system. The combination of these positive factors supports the proposal of conducting a study on all patients at Canterbury Hospital, and the evaluation of the financial impact of PHI

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use on patients and the hospital is a rational and realistic approach. Canterbury Hospital's medium hospital-bed base numbers means that a full-scale hospital-wide patient survey is possible. Such a study would attempt to sample the majority if not all of the patients staying at the hospital for a period to ensure that the population sampling is complete (where possible) in identifying all patients, regardless of their PHI status. Logistically, conducting such a study on the entire hospital's inpatient population is possible. According to Israel (1992), using the entire population (where possible) for a study is preferred over sampling, as it is more likely to resemble a real-world scenario. Attempts will be made to ensure that given the set date range, all inpatients will be surveyed, where possible. Individual patients' health conditions and their preference of whether or not to participate in the study would affect the likelihood of the response rate. For example, at Canterbury Hospital, there is an intensive care unit, a stroke and psycho-geriatric ward; it is expected that the response rates from these ward areas are likely to be low due to the nature of these clients' physiological and mental conditions. Also, it is possible that some patients may be sleeping, eating, away from the ward for surgery, or receiving active treatment, so are unable to complete the questionnaires. It should be noted that while conducting a census-like study such as this one does capture most patient responses in the hospital, any generalisation is based on the assumption that its representation of the larger population is reliable.

The information sheet attached to the survey is used to provide patients with informed consent; it is reasonable to assert that once a patient has read the information sheet and decides to complete the survey, the researcher has obtained informed consent from the patient. A contact number is provided for patients to contact the researcher, should they require further information in relation to this study. These steps are used to ensure that respondents are well informed of the



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study and that the maximum possible patient response rate is obtained for this research.

The content of this survey is based on the researcher's understanding of the literature and the topic area, experience through everyday work, and stories shared by staff and patients. Within the survey structure, there are also some traces of qualitative research elements as possible question answers – views and factors that may influence patients' decisions have to be listed as part of the survey question options. The survey itself will be a quantitative research tool used to collect data and to determine whether any correlations exist between the observed data and the facts. A unique aspect of this research is that it will be conducted in a hospital that services a local population that is highly diverse in terms of their language, culture and religious background.

The second part of the research utilises financial modelling through available archival data to determine the impact of encouraging patients using PHI in a public hospital on the individual patient and the hospital. Financial data that will be used for this study will be made available through the Health District's financial information systems. Pricing data for payable bed-day benefit can be obtained from PHIAC and NSW Health. Canterbury Hospital has a set of regular data-capturing tools employed in recording the number of patients who come through the hospital as an inpatient. The reporting function of the Patient Registration System is able to provide reports on inpatient admission by financial classification in Microsoft Excel or comma separated value formats. NSW Health releases pricing updates every July on the inpatient bed cost payable for private inpatient bed days. The Health District is able to provide financial data on private hospital inpatient income.

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This new research intends to explore the two aforementioned questions. There will be no hypothesis for the study, as it is an exploratory study. The first research method of a patient-survey study is relatively easy to replicate, the results can be retested by conducting the same survey again, and the survey can also be conducted in other hospitals. Financial modelling of the impact on patients and the impact on the hospital would be conducted without a hypothesis. Throughout the literature review, no previous study of this type or scale has been found, thus reinforcing the exploratory nature of the study, as the modelling is not aimed at proving a hypothesis that could be biased in nature. In relation to the testability of the model, a replicate of the study can easily be conducted again. For example, if another researcher were to conduct the same study in the target hospital, they could employ the same model mentioned here by applying a more up-to-date dataset and reconstructing the model based on the target hospital's specific financial data.

The last part of research would utilise secondary data obtained from a clinical redesign project conducted at Canterbury Hospital in 2012. This redesign project was undertaken by a number of staff from the SLHD aimed at improving private inpatient revenue at Canterbury Hospital. The project made a number of findings, some of which resulted in recommendations that are currently being progressively rolled out within Canterbury Hospital.

### **7.3. Research Instrument Justification**

The questionnaire used in this study is designed to focus on the issues of using PHI utilisation through a logical thought process. Format of the questionnaire is a two-paged table form in size 10 Arial font. The two-page questionnaire is not likely to be considered long by patients, and a font size of 10 also ensures that the questionnaire is relatively easy to read. Adequate space is provided for the answers when

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respondents need to elaborate on them. These measures are taken to increase the response rate by patients. The questionnaire uses simple, plain English to facilitate comprehension as well as for easy reference by scholars who are interested in the study. In general, the questionnaire design aim is that questions should be unambiguous, short, clear, do not require lots of effort to answer, and are not double-barrelled questions. The actual final questionnaire has been designed to accommodate such aspects of survey design.

Section 1 of the questionnaire is entitled “Private health insurance and you”. This section aims to determine the respondents’ PHI utilisation choice in general. Section 1 questions are ordered from general contextual questions to more specific questions concerned with particular issues.

Question 1 enquires if a member of staff asked the respondent when they were admitted whether or not they held PHI. There are two possible answers “yes” or “no”. It is used to determine if any respondents were not asked about this question upon admission. It is the key and the first step to determining whether or not the hospital staff are making an initial attempt to find out if patients hold PHI.

Question 2 asks if the respondent holds a current PHI with hospital cover. This question aims to explicitly determine who the study’s key target group is – so in the case of this study, people admitted to Canterbury Hospital holding PHI hospital cover. This question has three possible answers, “yes”, “no” or “not sure”. This is aimed at differentiating the target respondent groups. It is expected that a large portion of patients will answer “no” due to the fact that they do not hold PHI hospital cover. Respondents who selected this answer will be directed to Question 3, where they will be asked if they are likely to purchase PHI in the next 12 months. These two questions have been placed in this logical sequence, as Question 3 further explores

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respondents' attitudes towards purchasing PHI if they do not currently hold it. After respondents have answered Question 3, they will be thanked for participating in the study, as they are no longer required and should be excluded from the study.

A portion of patients who hold the cover may still falsely report that they do not hold the cover in Question 2, due to various reasons discussed in the previous sections of this study. Another portion of patients who hold the cover may accurately report that "yes," they do hold the cover and genuinely want to assist with the study. Some patients who may not be aware of their PHI status may select "not sure"; it is expected that a minimal amount of respondents will select this answer, as patients would generally know whether or not their PHI provides hospital cover.

For patients who answered "yes" to Question 1 (possessing PHI cover), they are asked to proceed to Question 4, where they will be asked to answer whether they have used their PHI during the current admission to Canterbury Hospital. There are two possible answers for this question, namely "yes" or "no". The dichotomous nature of the possible answers means that the respondents will be able to answer this question without confusion. If respondents answer "yes" they will be directed to proceed to Question 5, where a further exploration of the reasons as to why they have chosen to use PHI for this particular admission. If they answered "no" they are asked to proceed to Question 4 where they will be asked to outline reasons as to why they have chosen not to use PHI for the current admission.

Question 5 has eight answer options, and the respondents can tick as many applicable answers as they like. They are also given the option to provide alternative reasons if the options provided do not actually reflect any of their own. The eight possible answers are nominal-scale options, placed in no particular order. It is an

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appropriately structured question to capture factors that have influenced the patients' decisions.

In Question 6, respondents are required to provide a range of reasons for not using PHI despite actually having a PHI policy. Similar to the way in which the options are given in Question 5, respondents are free to select as many applicable answers as possible. They are also asked to provide any additional reasons if the listed options do not reflect their own situation/views.

Question 4 divides the PHI holders into two different groups. The motivations behind their actions and choices are explored in Question 5 and 6. Question 7 is a question aimed at assessing the consistencies and/or discrepancies behind a respondent's answers in Question 5 and 6. For example, if a respondent used PHI due to any free ancillary benefits (free TV hire, newspaper or parking) but answered the reason to purchase PHI is for tax purpose. It may seem that this respondent's original intent of buying PHI does not determine the decision of whether or not to use PHI – it may simply be due to free material benefits, which are so tangible and relevant that the respondent was compelled to use PHI. This question is important in understanding whether the decision making about using PHI is a rational one. A key point requiring understanding is when people make decisions about whether or not to use their PHI are they making the decision through thinking rationally weighing the benefits or is it less scientific and without much rationality. Possible responses in Question 7 are also in nominal scales without any particular sequence. Users can answer as many applicable reasons as they like.

The questions that followed on from Section 2, entitled "Knowledge about private health insurance" aim to explore how knowledge about PHI could impact on the decision to use it. Question 8 asks the respondents if they understood their health

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insurance cover very well. The five response categories are in ordinal scales: strongly agree, agree neutral, disagree and strongly disagree. McColl et al. (2001) have argued that seven response categories could increase precision, for example a Likert type of scale. However, due to the simple nature of the questionnaire, the five response-categories scale is adequate for the purpose of allowing respondents to answer the question in a general nature. Added response categories may confuse the respondents as they spend time trying to work out the differences between them.

Question 9 asks which staff member mentioned the prospect of using PHI to the respondents, and Question 11 aims to determine whether or not the respondents have seen any PHI-related promotional material in the hospital. These two questions have nominal scales in an attempt to list the answers that are likely to capture all the possible options. Respondents are able to select any number of options from the list of options, if they are applicable.

Staff who approach patients with information on PHI will need to talk to patients about using PHI in a public hospital. Question 10 asks the respondents how they would rate the level of PHI knowledge among hospital staff. Available response categories are the same as in Question 8, ranging from strongly agree to strongly disagree. These options are meant to be respondent-rated, and the accuracy of description is determined by the respondents. Answers from this question reflect the respondents' perceived trust in the public health system when it comes to financial decisions. It is important to understand these factors and whether or not any correlation exists between the element of trust and their decision to use PHI.

Respondents are also given the opportunity to tell the researcher if they have any additional general comments that they wish to make about the topic of this study in a free-text field. It is understood that some respondents may provide information that is

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not related to the study, which may be ignored. At the end of the questionnaire, the respondents can provide contact details to the researcher if they wish to participate any future studies. This is completely voluntary and the respondents are not obliged to provide their details if they do not wish to.

The hospital PPO, revenue manager and a number of Nurse Unit Managers (NUM) were consulted during the design of this questionnaire, and relevant adjustments were made as a result of this consultation. A pre-test of the questionnaire had occurred on a random hospital ward prior to the full-scale study's commencement in order to glean if any issues were missed, and to assess the administration steps of conducting the study operationally. In this pre-test, the feasibility and ordering of the questions were reviewed. The time it takes to complete this questionnaire has also been assessed. This pre-test had lead to adjustments of the final questionnaire. Changes to the research instrument include:

- Re-order questions to improve its logical flow
- Allow participants to provide open-ended answers to questions
- Administer the survey at meal times, morning and afternoon instead of only just at meal times to increase participant coverage
- Space out the survey time and fit in with ward availability based on comments from the NUMs

#### **7.4. Ethical Considerations**

This study focuses on the issues relating to PHI utilisation in NSW public hospitals through a site study at Canterbury Hospital, SLHD, and a unit within NSW Ministry of Health. This study was neither related to any foreseeable contentious issues, nor did it affect the treatment of any hospital patients; patients wishing to participate in this survey have been provided with information about what the research is about and

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what the research results will be used for. As part of the information briefing sheet to the participants, it has been made clear to all involved that participation in this survey is entirely voluntary, and that participants could remain anonymous and could withdraw from this research at any time, should they so choose to.

A standard SLHD research information sheet has been provided in writing to patients (Appendix 3). In consideration of the cultural diversity of patients who attend Canterbury Hospital, multilingual information on how to contact the interpreters for assistance has also been provided together with the survey.

An ethics application was required as part of the standard process in conducting research on patients within SLHD, as well as by the University of Tasmania. In the ethics application, it has been noted that this study is concerned with examining patients' financial decisions and PHI. It would not involve any information related to patient's treatment or privacy. Patients could remain anonymous and were de-identified in the study; it would not be possible to use the data obtained through this study in order to identify any individual patient in reverse. Due to the nature of the research, it is considered that the study is a low-to-negligible risk (LNR) study that does not involve patient treatment information or drug trials. This study was approved by the SLHD Human Research Ethics committee in 2011 (see Appendices 1 and 2). The ethics approval information has been attached to the survey tool, and appropriate contact numbers for enquiry have been provided, should any participants wish to obtain more information regarding the study.

Prior to the commencement of the study, the researcher had corresponded with the general manager of Canterbury Hospital, seeking permission to conduct the study and for relevant data captured by the hospital to be used for research purposes. The approval to conduct this study was granted by the hospital's general manager, which



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formed part of the original site-specific application approved by the SLHD HREC (Appendix 1).

### **7.5. Study Part 1 – Survey Procedures**

A study could be conducted on all inpatients during mealtimes and patient visiting hours at Canterbury Hospital. Inpatients elect their financial classification upon admission to the hospital. The most common financial classes are Medicare-only (MO) patients followed by private inpatients (PI), the Department of Veteran Affairs patients, workers' compensation patients and Medicare-ineligible patients, i.e. visitor inpatients (VI). In this study, regardless of these patients' financial classification, they will be asked to complete the survey questions. Conducting the survey at various visiting times is aimed at ensuring that most of the patients are available to answer the questionnaires, thus maximising data capture rate. Meal trays are used to deliver meals to patients; the survey and a letter advising patients of the purpose of this survey will be placed in the tray together with the meal. A pen will be provided to the patients to assist completing the surveys. A staff member visits each of the wards after the surveys are delivered to assist patients with the survey and help to answer their queries. After the patients have finished their survey, they can leave the survey in the envelope provided, which will be collected by hospital staff. After the completed surveys are collected, an administrative officer will assist by inputting the data in a spreadsheet with relevant column labels, indicating answers for each question. This is to prepare for the researcher who will analyse the results in the data analysis stage. Answers that were not provided by patients are noted in the data-collection spreadsheet as "not answered".

The survey questionnaire is short and uses simple English so it is easy to understand. This stage of data collection is to understand the patients' PHI status

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and study their reasons as to whether or not they have chosen to use their PHI. Key variables intended for capture in this study include: the number of total admitted patients, how many patients held PHI, how many patients actually used PHI in the admission. The participants are required to provide information on the reasons behind why they decide whether or not to use PHI. A detailed sample of all the research questions is included in the Appendix section (see Appendix 3). Measurements and the rationale behind the way in which this questionnaire was designed is explained in the research methods chapter.

When carrying out the survey, it is considered a good idea to use a random set selection of survey days that are at least 4 weeks apart from each other. By spreading the survey dates out, this reduces the chance of surveying the same patient, and also allows the survey to be conducted more times, thus improving the reliability of the sample representing the wider patient population.

## **7.6. Study Part 2 – Financial Modelling Procedures**

As discussed in previous sections, it is imperative to understand what financial impacts are there to a public hospital in providing benefits to patients who choose to use their private health insurance. There has been no study previously in understanding what such cost is, this chapter aims to answer that question. Calculation used in this chapter is based on the following formula: **Net Revenue = Total revenue - (Total cost of goods and services plus or minus cost adjustment).** Where total revenue equates to PHI revenue the hospital earned through patients using their PHI. Total cost of goods and services are the costs involved in providing benefits for patients who choose to use their PHI. Cost adjustment is the difference between what the hospital would have paid the visiting medical officers if the patient is a public patient

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Data collection for the second research question requires research based on financial information, and this part of the study would therefore not necessarily be based on an experiential study. The data required for this part of the study would firstly include the cost of using PHI for the individual patients, the cost of encouraging patients to use PHI through offering benefits such as free newspapers, free TV/Telephone, free parking, free toiletry pack (in the instance of Canterbury Hospital, these are the only benefits being provided to PHI patients) the time spent by private patient officers (PPOs), administrative staff, finance staff etc. The guiding principle for this part of the study is that not only should the revenue gained by the hospital be accounted for, but the cost incurred by the hospital in encouraging patients to use their PHI or the methods used to attract new patients should also be made clear. In addition to this, there is a need to quantify other costs or benefits that are not directly measured by monetary value, e.g. cost of time spent by administrative officers trying to convert a patient, the potential extra cost for the hospital as potentially private hospital work is shifted to the public hospital, etc. The archival data search should be conducted on total PHI patient fees, patient volume, projected return etc. through the hospital's own information systems. By putting these two sets of data together, a model could be constructed to assess the effectiveness of the hospital's current strategies in encouraging patients to use PHI, and the financial returns of doing so.

### **Data collection and analysis**

This chapter describes how the data would be collected and analysed.

#### **Part 1:**

When the main research questionnaire has been completed, one of the administrative officers working at Canterbury Hospital had entered the result for each of the questions into a Microsoft Excel spreadsheet. The spreadsheet was designed

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in such a way that it identifies the questions and their corresponding answers clearly. For example, survey Question 5 asked the respondents to explain reasons for using PHI, and provided 8 possible answers, and all the possible options appeared in the spreadsheet with 1 representing “yes” and 0 representing “no”. All responses that were completed or partially completed will be recorded in this spreadsheet together with the corresponding fields. Missing data, or any answers left unanswered were known as “Not answered” with the notation of “Nil” in the spreadsheet. This method of data transcribing ensures that all corresponding questions and answers are presented in such a way that it reflects the original questionnaire structure.

Upon completion of data collection from the study, the data was then interpreted through a series of analyses. These analyses aimed to identify the various frequency counts of answered options, and the likelihood of the variables.

For the data collected during the survey on PHI utilisation (Question 5 as an example) a descriptive ranking had been made to outline which of the reasons constitute the most prevalent to the least prevalent in affecting the patients’ decision about whether or not to use their PHI. During the data analysis, the ranking of such results were simply carried out using frequency counts in order to illustrate their relative importance and the likely outcome these variables may have. With questions that had a dichotomous answer, options the data analysis examined the percentage of people answering “Did you use your PHI for your admission?” or “Did a staff ask you if you hold PHI?”. The percentage to each of the dichotomous answers was then compared with the responses provided for their decision about whether or not use PHI. The data analysis aims to identify any patterns that could produce meanings that were not instantly apparent.

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There were also some answers to the question that were presented in ordinal scales. These questions include: “How do you rank your understanding of your PHI policy?” and “Was the member of staff who informed you about choice of financial election knowledgeable about private health insurance?”. For the data analysis concerning respondents’ knowledge of their PHI policy, the results were compared with the respondents’ propensity toward using the policy in the public hospital. The analysis can identify whether or not there is a correlation between good understanding of policy and actually using PHI, or vice versa. On the other hand, with the data analysis concerning staff knowledge on PHI, the analysis compared the respondents’ rating and their propensity toward using the PHI, or vice versa. The aggregate of the result from this question, if the respondent indicates an apparent lack of staff PHI knowledge, then it would have produced a useful analysis result in developing a remedy to increase staff knowledge in the area. In addition, the questions that aim to identify the various PHI communication opportunities the respondents have had during their hospital stays were analysed together with their final choice of whether or not to use PHI. This small analysis was useful in identifying if any of these communication strategies had contributed to their final decision to any degree.

SPSS version 18 and Microsoft Excel version 2003 have been used jointly in conducting the data analysis. SPSS’s strength in data analysis and conducting significance test had benefited the data analysis part greatly. Microsoft Excel has the ability to import, export and reformat data in various ways and produce a graphical representation of data analysis. These functions have been useful when conducting the analysis and presenting the findings of the analysis.

Analysis of the data has been conducted in order to understand respondents’ views, opinions, personal experience and their relevancy to PHI utilisation. The

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measurement of likelihood of PHI utilisation, by way of analysing correlation between the answers provided in various questions, may not take data variation into consideration. Some data obtained may be abnormal or considered as anomalous due to the above reasons.

## Part 2:

Archival data collected for the second part of the study help to facilitate a financial modelling on both individual benefits versus cost and hospital benefits versus cost. There had been attempts made to ensure that the data obtained in this stage were defined accurately and analysed for their application in the study. Several likely analyses required in this stage of data analysis are listed as below.

Firstly, an analysis looked at what the average cost of an individual using PHI would be; this data had been constructed into an aggregate model in order to understand the average cost for a typical patient admission using PHI versus admission as a public Medicare patient. There are several variable factors involved, such as how the patient entered the health service and what type of insurance policies they hold. Private patients entering Canterbury Hospital via the ED do not have to pay any OOP expenses, whereas they may have to pay if they come via the elective surgery corridor. The cost modelling for the individual will be quite different based on their mode of entry to the hospital. Furthermore, individuals' personal circumstances and the type of cover they have may vary, and these factors could all affect the way in which this model would be constructed. Moreover, tangible benefits such as free newspapers, free parking etc. can be seen as having a positive financial impact to the patient, and these values could be added directly as benefits. It should be noted that the model is a way of predicting the general cost and benefits for the individual, not to exhaustively calculate what the cost or benefits are, precisely down to the last

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cent. Therefore, it may not be exactly practical to utilise a cost model to measure an individual's perceived and actual utility of using PHI.

For the hospital in the context of PHI utilisation, benefit and cost data is collected through the central financial information system controlled by the SLHD. A similar model to the abovementioned can be constructed based on the financial data obtained to determine the cost versus revenue raised as a result. The analysis focused on the concept of ROI, a key financial analysis ratio that is being widely used in the commercial world (Laitinen, 1991). In essence, this analysis applies the ROI model to evaluate the effectiveness of the investment – financial costs involved in encouraging and converting patients to use their PHI (tangible benefits, waiver of fees, cost of resources, etc.) and financial return – various revenues, including patient fees revenue (income received from the insurance companies), prosthetic device revenue, diagnostic and pathology test revenue, etc.

### **7.7. Study Part 3 – Explore Methods To Increase PHI Conversion Rate**

At the end of the survey there is the opportunity for the respondents to express their views about the matter of PHI utilisation in a qualitative manner. This may be beneficial in understanding and further exploring the issues identified in the main part of the survey questionnaire. In particular, the qualitative part of the survey can be seen as a follow-up qualitative study that is aimed partly at exploring issues surrounding patients' hospital experience, interaction with various staff, the service and the impact these factors have on their decision of whether or not to use PHI. It is useful to explore the psychological decision barriers deterring them from using their PHI policy, as well as what underlying elements key in converting them from Medicare to using their PHI. However, the degree of information the respondent is

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willing to provide depends on the willingness of the individual answering the qualitative question.

If patients' answers provide any relevant answers in the field of motivation in PHI utilisation, the descriptive part of the survey could be used to understand patients' preferences regarding what they perceive to be the pivotal value that will convince them to use their PHI policy in a public hospital. It is possible that that patients may provide a range of answers in this chapter, ranging from altruistic options to materialist options. Their answers may include: assisting the hospital, assisting the community, free TV, free newspaper, free parking, complementary toiletry packs and choice of doctor, and as such, these answer options should be present in the survey.

Patients are given the choice of remaining anonymous in this study. It is difficult to estimate how many patients would be willing to answer this part of the study. From a research-procedure point of view, the free text part focuses on patients who may have the willingness to identify issues relating to their reasons for using or not using PHI.

## **7.8. Constraints, Assumptions & Possible Limitations Of The Method**

### **Part 1**

While the research is aimed at capturing as complete a picture as possible, by assessing the entire hospital's admitted population, it is not without its weaknesses. Every effort was made to ensure that the response rate from the study was maximised. Firstly, the language of the survey is designed in easy-to-understand English. Jargon and long sentences are avoided and the questions are specific and non-ambiguous, making the survey easy to answer. There is the possibility that



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some non-English speaking background (NESB) patients may not have completed the survey due to the language barrier, even though the contact details of a free interpreter service was listed on the back of the survey. These factors would, however, affect the reliability of the results obtained, to some degree.

Furthermore, some patients may consider the survey result to be an official hospital record may choose to falsify certain information provided. Or, for the same reason, and also because the survey is voluntary, some may chose not to participate in this study at all. These factors could all affect the amount of data captured as well as the quality of the data obtained in the study. Patients were advised in writing that the participation of this survey was voluntary and that the information provided is confidential and would not be disclosed to any third parties. The patients were further advised that they could remain anonymous, and the information provided would not in any way affect their hospital treatment. These efforts were used to alleviate participants' concerns or the fear of any negative consequences from participating the survey. Nevertheless, it is recognised that even with the effort put into to informing patients of the purpose of the study and helping them to complete the survey, some patients who do not wish to participate the study, simply will not.

## **Part 2**

An analysis of the financial implications of encouraging patients to take up PHI is based on data obtained from secondary sources. Data accuracy is dependent on the reliability of the data source from which this data is collected. The accuracy of this data may be beyond the control of the researcher. It is likely that some of the financial implications or resource utilisation may need to be based on best-guess estimates and variations. For example: the number of minutes an administrative officer spends on patient interviews, or the equivalent monetary value of the time

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spent on the interview, can only be based on a best-guess estimation. From an individual-patient benefit and cost point of view, because each patient's personal circumstances are different, there is a need to estimate what the likely benefits for patients will be (equating to the dollar value benefit of these "free" benefits that they will be receiving). Other benefits, however, are not easily quantifiable in dollar terms, for example: patients may have chosen to go to Canterbury Hospital simply due to its close proximity to their home, rather than going to another private facility that is located in another suburb.

Patients could also have a vested interest going to a public hospital simply to obtain the benefit of "excess waived", and then later choosing to go to a private hospital because the public hospital has already paid for their excess in that calendar year. It is not clear as to how many patients simply go to public hospitals for this purpose, however it is important to understand that the methodology employed in this study is unlikely to eliminate the data-reliability problem caused by these patients using the public hospital system for another purpose, and then choose not to disclose that information in the survey. However, it is assumed that the percentage of patients who use the public hospital to reduce their excess liability would be low. The purpose of doing this is to go to a public hospital as a private patient, the public hospital would waive the excess fees and then a patient could be transferred to a private hospital and does not have to pay for an excess for that year. There is generally a low number of private patients who are transferred to a private hospital subsequent a public hospital transfer.

Proposals made in this study regarding ways to encourage more patients to use PHI may not always be practical or realistic in the public healthcare system, where some strategies may create perceived inequality between patients. In addition, the

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recommendations made could also be subject to budgetary and resource constraints that are beyond the control of the researcher. Recommendations for any future strategies will be assessed based on their practicality, in order to ensure that they are achievable and realistic.

## **Assumptions**

There are a number of assumptions made for the new study:

- That patients who have a very basic command of English will be able to understand the content of the survey, and that while contact details for a free interpreter service is provided to all respondents in order to afford as much support as possible to NESB respondents, these patients will choose not to contact an interpreter for completion of the survey.
- Financial data relating to patient fees revenue are assumed to be accurate and from a trustworthy source (SLHD financial information system), and will be adopted directly for the financial modelling.
- A portion of patients with PHI but chose not to use their cover is willing to provide some information in the survey about their reasons for not using PHI.

### **7.9. Real Potential Of Private Patient Conversion**

While a large number of the Australian population holds PHI among the general population (46.9% of all Australians hold PHI with hospital cover; PHIAC, 2012b), one may argue that it is incorrect to assume that this percentage is the same for the entire hospital inpatient population. In fact, approximately 28% of the population hold PHI with hospital cover in the most socio-economically disadvantaged communities in Australia. There are several reasons to support this argument. For example, it is possible that lots of people who hold insurance may never use it because they are

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healthy and have only purchased the insurance policy for taxation reasons or for a piece of mind. In addition, the assumption that the population who entered the hospital ED may have the same PHI membership rate as the general population within the community is flawed, as research has shown that patients who visit the public hospital's ED generally tend to have a lower socio-economic status than the general community's population (Clay & Ozanne-Smith, 2006). Therefore, it may not be reliable to generalise the patient population of the ED with that of the hospital's whole general population.

Research has shown that patients who have higher socio-economic status generally take better care of their own health. They are less likely to need to visit hospital's ED, as usually health issues are looked after before they require emergency treatment. It may also be argued that sometimes, people holding PHI insurance may tend to be people of higher socio-economic status because they can actually afford to pay the premiums for their insurance cover (Bernard, Banthin, & Encinosa, 2009). Therefore, some scholars have argued that the percentage of patients visiting the ED who hold PHI may be lower than that of the general population.

Based on such rationale, it is reasonable to assume that public hospital population's PHI membership percentage may be lower than the local area's PHI coverage percentage. However, it is not accurate to assume that this is always the case without empirical evidence.

This chapter summarised the range of methods utilised for this research including its pilot test, the justifications of the methods and the procedures of how the research instruments were used. A range of considerations were also documented in this chapter including ethical consideration, constraints, assumptions and possible limitations of the methods.

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## **8. Result Reporting And Analysis**

This chapter follows on from the previous Methods chapter and reports on the results obtained from the research and what analysis have been conducted. It document both quantitative and qualitative data collected and provides analysis for both the survey result and the financial modelling result. Lastly, this chapter documented the secondary result obtained from a clinical redesign project conducted at Canterbury Hospital and provides an analysis on the result.

### **8.1. Survey Result Reporting And Analysis**

At Canterbury Hospital, between August 2011 and March 2012, approximately 450 patient surveys were conducted through a random-set selection of survey days that were at least four weeks apart from each other. This is to reduce the chances of surveying those patients who are being kept in hospital for long periods of time more than once. Based on the survey results obtained from 336 patient surveys (74.67% response rate, across a period of approximately 8 months), the report is presented by listing each survey question, documenting the answers to these questions and providing any notes on the data collected. Several questions in the survey provide an opportunity for the respondents to give free-text answers. These answers are analysed by Statistical Package for the Social Sciences (SPSS) and categorised into groupings that are of similar themes; if these answers reflect a similar theme as one of the options then they are counted towards the frequency count for that option; alternatively, if the answers reflect a new theme, then it will be grouped into a new category of answers.

1. Have you been asked by a staff member if you hold private health insurance during this admission to the hospital? Yes or No					
		Frequency	%	Valid %	Cumulative %
Valid	0	132	39.3	39.3	39.3
	1	204	60.7	60.7	100.0
	Total	336	100.0	100.0	

Table 1.1. Survey question answer 1

A “no” answer to this question represents the “0” value, and a “yes” answer to this question is represented by the “1” value.

This result indicates that 60.7% of respondents (204 out of 336) reported that they had been asked by a staff member whether or not they held PHI. On the other hand, there were 39.3% of respondents (132 out of 336) reported that they had not been asked by a staff member whether or not they held PHI.

2. Do you hold a current private health insurance policy with hospital cover? Yes or No					
		Frequency	%	Valid %	Cumulative %
Valid	0	263	78.3	78.3	78.3
	1	73	21.7	21.7	100.0
	Total	336	100.0	100.0	

Table 1.2. Survey question answer 2

A “no” answer to this question represents the “0” value and a “yes” answer to this question is represented by the “1” value.

The result from the question above suggests that 21.7% of respondents (73 out of 336) reported that they held a current PHI policy with hospital cover at the time of the survey. Although the result is only indicative of who had responded to the questions in the hospital during the survey, it is still perhaps useful in representing the local population. Should this assumption be right, and if all the patients who had PHI had answered the questions truthfully, then there appears to be the potential for 21.7% of patients admitted in the hospital to be using their PHI. However, on the other hand, the amount of patients who answered the question could be lower than the amount of patients who actually hold insurance, as some respondents may not disclose any information in relation to their PHI coverage status. In other words, the estimation of the number of PHI holders at a public hospital who could potentially be using their PHI but are not is only dependent on their willingness to declare their PHI status.

3.1 Do you intend to purchase private health insurance in the next 12 months? Yes or No					
		Frequency	%	Valid %	Cumulative %
Valid	0	319	94.9	94.9	94.9
	1	17	5.1	5.1	100.0
	Total	336	100.0	100.0	

Table 1.3. Survey question answer 3

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A “no” answer to this question represents the “0” value and a “yes” answer to this question is represented by the “1” value.

A small percentage (about 5.1%) of respondents expressed through this survey that they intend to purchase PHI in the next 12 months following the survey. Almost 94.9% of patients responded “no”. Answers to this question are indicative of the population’s general attitude towards PHI. The low number of respondents wanting to purchase PHI as part of the hospital population could mean that those of the population who answered the hospital survey may have come from a lower socio-economic background. A reason for this prediction is due to the relatively low socio-economic status of Canterbury local government area. This may also mean that a large proportion of patients who have a Medicare card and are relying on the public healthcare system are probably happy with the status quo and would not want to make the additional financial commitment of purchasing PHI. Perhaps also on the other hand, the respondents may already hold PHI cover, and that is probably why they answered that they wouldn’t be purchasing PHI. The chance of the latter option may be slightly slim, as answers from the above questions indicate that there is not a large proportion of patients who reported themselves as holding any existing PHI cover; it may instead be more likely that the population in general at the surrounds of Canterbury Hospital has a low level of PHI membership, and there is probably no intention by this general population to change this situation in general.



4.1 Did you use your private health insurance for your admission this time to Canterbury Hospital? Yes or No					
		Frequency	%	Valid %	Cumulative %
Valid	0	278	82.7	82.7	82.7
	1	58	17.3	17.3	100.0
	Total	336	100.0	100.0	

Table 1.4. Survey question answer 4

“No” answer to this question represents the “0” value and a “Yes” answer to this question is represented by the “1” value.

58 out of 336 (17.3%) of the respondents said that they had used PHI for the time when answered the survey. 278 (82.7%) of respondents said that they did not use PHI. This may also include people who do not have PHI but still answered “no” to this question. It is worthwhile to note that while it has been reported through this question that 17.3% of the respondents said they had used their PHI, the average PHI capture rate through this period was around 11%. It could be that some patients may have used other types of insurance policies, such as worker’s compensation, travel insurance and motor vehicle accident authority insurance, rather than PHI, while believing that they had in fact used PHI. On the other hand, there could possibly be a lack of trust and avoidance of contact with the health service, therefore respondents may have answered that they had used PHI in order to avoid being approached again by staff.

5. Why did you use your private health insurance for your admission this time to the hospital? (Please tick as many of the below answers that apply) * 58 people responded to this question out of 336			
	Options	Frequency	% (Frequency/No..of respondents)
1	Choice of my own doctor	25	43.10%
2	Possibility to be admitted to a single room	42	72.41%
3	Was told won't cost me anything so just signed up	41	70.69%
4	Free TV hire	5	8.62%
5	Free parking	5	8.62%
6	Free newspaper	3	5.17%
7	Free toiletry pack	2	3.45%
8	Waived my excess	40	68.97%
9	Help the hospital and the community	26	44.83%
10	Other reasons, please specify	10	17.24%

Table 1.5. Survey question answer 5

This question provides a range of responses for respondents to choose from; it is possible that the respondents may choose more than one answer from the range of options listed.

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For Question 5, where respondents are provided with the opportunity to reflect on the reasons as to why they have chosen to use PHI, 58 out of 336 respondents responded to this question. Out of these responses, it was noted that 4 issues were important:

- a. 2) Possibility to be admitted to a single room (72.41%);
- b. 3) Was told won't cost me anything so just signed up (70.69%);
- c. 8) Waived my excess (68.97%);
- d. 9) Help the hospital and the community (44.8%).

An important point to note is that at Canterbury Hospital during the research period, there was no offering of free TV hire, no free parking, and no free newspaper; the only perk on offer was a complementary toiletry pack. However, some respondents still answered that they used their PHI because of these free benefits. This could be due to a misunderstanding of the questionnaire as asking "what would have made you wanting to use your PHI during your hospital admission".

It can also be noted that 26 out of the 58 respondents, or 44.83%, had responded that one of the reasons as to why they used their insurance during their stay at Canterbury Hospital was "9) Help the hospital and the community". It can be seen that a significant amount of people who are willing to approach the use of PHI in a public hospital for an altruistic reason. It may be because some of these such respondents like to portray themselves as good citizens, even though the answers are not attributable to any individual; however, the amount of people who are willing to use their PHI if they know that they are helping the hospital should be noted.

Interestingly, almost all of the "other" respondents for option10 stated that the reason for their choice to use their PHI was because they think believe they should use the

insurance premium they've already paid for, while the rest believed that the information provided by staff was informative and thus decided to use PHI.

6. Why did you choose NOT to use your private health insurance? (Please tick as many of the below answers that apply)			
* 26 people responded to this question out of 336			
	Options	Frequency	% (Frequency/ No. of respondents)
1	I didn't want to pay an excess	3	11.5%
2	I didn't think about using it	4	15.38%
3	I'm worried about the doctor's fees (gap charges)	5	19.23%
4	I'm worried that my insurance premium may go up if I claim	6	23.08%
5	I didn't think private health insurance covered my public hospital stay	16	61.54%
6	I was not asked about using it	2	7.69%
7	A hospital staff told me not to use it	0	0%
8	Someone else told me not to use it	1	3.85%
9	Other reasons, please specify	1	3.85%

Table 1.6. Survey question answer 6

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This question provides a range of responses for respondents to choose from; it is possible that the respondents may choose more than one answer from the range of options listed.

Results obtained from question 6 were concerned with respondents' reasons for choosing not to use PHI. 26 out of 336 respondents answered this question. This response rate is considered to be low, as it represents only 7% of the respondents in the survey. This could be due to myriad reasons; one of these reasons could be due to the effectiveness of the hospital's PHI promotion campaign in that most people who have PHI have chosen to use it. However, as answers indicated in Question 2, 21.7% of the respondents answered that they did hold PHI with hospital cover, and during the corresponding period, Canterbury Hospital's PHI conversion rate was averaging about 11%. The 7% response rate means that it is possible that at least 4% of the patients who have PHI with hospital cover in the hospital during their admission did not use their insurance.

There is some limitation to this assumption however, as it is not clear whether some respondents had mistaken their PHI cover with student health insurance (a form of health insurance for overseas students with similar coverage as Medicare, paid for by the student). Also, there is the possibility that some of the respondents, did not use their PHI cover due to their being prevented by doing so by the policy's waiting period and that their insurance policy was not effective at the time of their admission. Other reasons could be due to the fact that their admission was the result of workplace injury or a motor vehicle accident, so they would have been covered under a different type of funding scheme, which does not require the use of their own PHI policies. All of these reasons are objective and substantial reasons as to why the patients might not have used their insurance; nevertheless, it may still not indicate

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whether or not these respondents would have used their PHI cover had they not been restricted in these ways.

One prominent feature is that 16 of the 26 (61.54%) respondents said that they did not think PHI covered their public hospital stay. Six (23.08%) respondents said that they were worried that their insurance premium may go up if they claimed from the health fund. It can be seen through the answers in this question that the fear of financial loss and a lack of knowledge prevents people from actually using their PHI for a public hospital admission.

7. Why did you purchase private health insurance? (Please tick as many of the below answers that apply)			
* 78 people responded to this question out of 336			
	Options	Frequency	% (Frequency/No. of respondents)
1	For my admission to a private hospital	8	10.26%
2	For tax purposes	1	1.28%
3	Always had it	17	21.79%
4	Parents had it	2	2.56%
5	Just in case that I ever need it	36	46.15%
6	For peace of mind	41	52.56%
7	Family circumstances changed	33	42.31%
8	Enable quicker access to care	14	17.95%
9	Other reasons, please specify	6	7.69%

Table 1.7. Survey question answer 7

This question provides a range of options for respondents to choose from, it is possible that the respondents may choose more than one answer from the range of options listed.

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Respondents were asked to respond to Question 7 in relation to the reasons as to why they decided to purchase PHI cover. Respondents are able to answer as many options as may apply. 36 of the 78 (46.15%) respondents said that they used the insurance just in case that they ever needed it. 41 of the 78 (52.56%) respondents said that the reason they purchased insurance was for peace of mind, which reflects that when it comes to health-related matters, people tend to avoid risks.

It should be noted that according to the ABS (2006), the 2004–05 NHS revealed that the most commonly reported reasons for having PHI were security/protection or peace of mind (43%), shorter wait for treatment or concern over public hospital waiting lists (23%), and having always had it, parents pay for it, or as a condition of their job (23%).

A group of respondents for this question answered that they had purchased PHI for their admission to a private hospital (8 respondents, or 10.26%) and 14 respondents (17.95%) responded that they had purchased PHI to enable quicker access to care. It could be argued that the respondents may have thought either that going to a private hospital would enable quicker access to care, or they might have thought that using PHI would mean a shorter waiting time for surgery. However, if these two groups are put together, where the assumption for enabling quicker access to care resides with private hospital care, a rather significant portion of patients may have hoped that their PHI cover would be used primarily for their treatment at a private hospital or in order to access care quicker. However, instead of receiving private hospital care, for this particular admission they have entered the public hospital system or served waiting period on a public hospital waiting list. Indeed, there are other factors related to the decision of whether or not to use PHI that could be involved at this point; for example, waitlist priority is determined by clinical priority



rather than a patient's financial classification (Taylor et al., 2002). Respondents to this question may indicate factors that they consider relevant to the reason for their decisions.

It is also important to note from the 2005–5 NHS (ABS, 2006) that almost two thirds (64%) of those without PHI reported not insuring because they could not afford it or it was too expensive (an increase of five percentage points from 2001). This was the most commonly reported reason for not having PHI across all age groups and income groups.

In the “other” group, the respondents had mainly said that they purchased PHI for security and peace of mind.

8. Do you think using private health insurance will make your insurance premium go up?			
* 77 people responded to this question out of 336			
	Options	Frequency	% (Frequency/No. of respondents)
1	Yes, because I used it	18	23.38%
2	No that's not the reason, because it will go up anyway each year even if I don't use it	33	42.86%
3	No, it will not change the amount of premium that I pay	7	9.1%
4	Not sure	19	24.68%

Table 1.8. Survey question answer 8

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This question provides a range of responses for respondents to choose from; it is possible that the respondents may choose more than one answer from the range of options listed.

A significant number of respondents who answered this question (33 + 7 or 42.86% + 9.1% = 51.96%) believed that using their PHI and claiming from the health fund is not what affects the increase in their insurance premium. On the other hand, 23.38% (18 out of 77) respondents believed that the premium would go up if they used it. 19 respondents (24.68%) did not know whether using the insurance would make their insurance premium to go up. Answers from this question represent that approximately half of the respondents who answered this question are still misinformed about the implications of using their PHI; that is, they are not sure whether or not their insurance premium would go up if they used their insurance. This misconception could be a major barrier in preventing these patients from using their PHI.

<b>9. I understand my health insurance cover (inclusions, exclusions, excesses, premium etc.) very well?</b> <b>* 74 people responded to this question out of 336</b>			
	Options	Frequency	% (Frequency/No. of respondents)
1	Strongly agree	25	33.78%
2	Agree	42	56.76%
3	Neutral	6	8.11%
4	Disagree	1	1.35%
5	Strongly disagree	0	0%

Table 1.9. Survey question answer 9

This question provides a range of options for respondents to choose from; it is possible that the respondents might choose more than one answer from the range of options listed.

From the answers of Question 9, it appears that a significant amount of respondents (67 out of 74, or 90.54%) agree or strongly agree that they understand their health insurance cover very well. It is important to highlight the fact that is the subjective view of the respondents themselves. It needs to be noted that in Question 6, more than 60% of the respondents did not know that they could actually use their PHI cover for their public hospital admission. Certainly, there is the “free” Medicare

means of being admitted as a public patient, however, when more than 60% of the respondents say that they are not sure they could use their PHI cover for an admission to a public hospital, this indicates a gap in their knowledge of their own PHI policy.

10. Who approached you or mentioned to you about using private health insurance? (Please tick as many of the below options that apply)			
* 70 people responded to this question out of 336			
	Options	Frequency	% (Frequency/No. of respondents)
1	Emergency department clerical staff	23	32.86%
2	Admissions/enquiries staff	17	24.29%
3	Waitlist staff	1	1.43%
4	Ward staff	22	31.43%
5	My specialist doctor	3	4.29%
6	Family members/friends	3	4.29%
7	Other, please specify	7	10.00%

Table 2.1. Survey question answer 10

This question provides a range of responses for respondents to choose from; it is possible that the respondents may choose more than one answer from the range of options listed.

Question 10 is intended to assess the contact that staff members have had with patients in encouraging them to use PHI. 32.86% (23 out of 70) of respondents said that ED clerical staff were the ones approached them about using PHI. A small number of respondents (4.29%) reported that their specialist doctors have mentioned to them about using PHI. The same number of respondents (4.29%) reported that family members or friends mentioned to them about using PHI. Among the 10% of people who had specified “other”, some respondents said that they had either self-elected or had seen information from the hospital patients’ guide.

11. Was the staff member who informed you about choice of financial election knowledgeable about private health insurance?			
* 72 people responded to this question out of 336			
	Options	Frequency	%  (Frequency/No. of respondents)
1	Strongly agree	5	6.94%
2	Agree	41	56.94%
3	Neutral	11	15.28%
4	Disagree	8	11.11%
5	Strongly disagree	7	9.72%

Table 2.2. Survey question answer 11

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This question provides a range of responses for respondents to choose from; it is possible that the respondents may choose more than one answer from the range of options listed.

Respondents are asked to report on their perception of the staff member who informed them about choice of financial election, i.e. whether or not they were knowledgeable about PHI. There were five possible answers, and the respondents were only allowed to choose one option. 72 out of 336 respondents answered this question. 63.88% of respondents stated in their answer that they either “agree” or “strongly agree” that the staff member who informed them about financial election was knowledgeable about PHI. 11% selected neutral, indicating they neither disagree nor agree whether the staff member was knowledgeable about PHI. 15 out of 72 respondents (20.83%) indicated that they consider the staff member who informed them about choice of financial election was not knowledgeable about PHI. It should be noted that 9.72% of respondents strongly disagree that staff member was knowledgeable about PHI. The last two answers should be noted particularly as it indicates that 20% patients perceive that hospital staff who they came in contact with did not demonstrate a good level of understanding about PHI. This further suggest that there may be room to improve the level of training for staff so that they acquire the necessary knowledge about PHI and can advise patients confidently.

<b>12. I have noticed information about using private health insurance at Canterbury Hospital through the following communication medium: (Please tick as many of the answers below that apply)</b>  <b>* 51 people responded to this question out of 336</b>			
	Options	Frequency	%  (Frequency/No. of respondents)
1	Telephone on hold message	0	0%
2	Hospital patients guide	4	7.84%
3	Hospital posters	13	25.49%
4	Hospital brochures	5	9.80%
5	Other, please specify	32	62.75%

Table 2.3. Survey question answer 12

This question provides a range of options for respondents to choose from; it is possible that the respondents may choose more than one answer from the range of options listed.

Question 12 examines the effectiveness of PHI-related promotional tools at Canterbury Hospital. 51 out of 336 people answered this question, in which 25.49% reported that they had seen the hospital poster encouraging patients to use PHI. This answer is considered low, as more than 50 posters (A2 and A3 size in bright orange colour) had been posted in lifts, waiting rooms and reception areas around the hospital. For option 5 in Question 12, where the free-text option is available, 16 out of the 32 respondents (50%) said that they did not see any material related to

PHI promotion; however, the rest of the respondents had said that either their own family members or a staff member had mentioned to them about using PHI. These answers from question 12 indicate that the efforts by the hospital in increasing awareness of PHI utilisation have been quite effective, and should perhaps be continued.

<b>13. If you have private health insurance (with hospital cover) what would make you want to use your private health insurance next time if you are admitted to a public hospital? (Please tick as many of the answers that apply)</b>  <b>* 69 people responded to this question out of 336</b>			
	Options	Frequency	%  (Frequency/No. of respondents)
1	Choice of my own doctor	47	68.15%
2	Possibility to be admitted to a single room	62	89.85%
3	Was told won't cost me anything so would just sign up for it	58	84.06%
4	Free TV hire	32	46.38%
5	Free parking	40	57.97%
6	Free newspaper	23	33.33%
7	Free toiletry pack	24	34.78%
8	Waiving my excess	59	85.51%



9	Help the hospital and the community	44	63.77%
10	Other reasons, please specify	11	15.94%

Table 2.4. Survey question answer 13 (cont.)

Question 13 examines prospectively what patients consider to be the important factors that would make them willing to use PHI when admitted to the public hospital. Overwhelmingly, the top three reasons that patients value the most are “possibility to be admitted to a single room” (89.85%), “waiving my excess” (85.51%) and “was told won’t cost me anything so would just sign up for it” (84.06%). The implications of answers provided for this question are significant, as the answers reflected very similarly what patients have responded in Question 5; the top three reasons as to why patients would choose to use PHI are the same as the three reasons identified for this question. It should also be noted that the next two high percentages representing reasons for using PHI are also matched between Questions 5 and 13, that is, “help the hospital and the community” (63.77%) and “choice of my own doctor” (68.15%).

It should also be noted that although there are differences in magnitude for some of these percentages, the fact that the order of significance of those answers was consistent in these two questions is very important. It shows that the respondents have a consistent view of what they feel are the most valuable factors that could ultimately influence their decision of whether or not to use PHI for their public hospital admission. For the respondents who had answered “other”, about 50% had mentioned that they would choose to use PHI in the future if they were to receive some sort of benefit as a result of it. The other half of the respondents effectively said that it would be a draw if they were able to choose their own doctor/clinician for

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care. The result of the answers in the “other” field further amplifies the result of the options in Question 13, in particular other benefits and choice of doctors.

Question 14, “additional comments relating to this survey on private health insurance”, offered respondents a free-text field to allow for a range of open-ended answers. Only 12 out of 336 respondents answered this question; half of the 12 respondents effectively said that they could not afford to purchase PHI, and some of the respondents effectively said that they felt disappointed that they could not be admitted to a single room.

## **8.2. Financial Modelling Result And Analysis**

Financial benefit and cost modelling analysis for patients using private health insurance at Canterbury Hospital - Financial Year 2011/2012

### **Financial benefits:**

Total private patient fee revenue raised during the financial year:

- Diagnostic and pathology fees revenue
- Prosthesis rebate fees revenue
- Accommodation fees revenue
- Staff specialist (Level 1) private patients consultation fees revenue\*
- Private patient upfront excess and gap payment revenue

Calculation method: the sum of all above revenue components

A staff specialist who works full-time at the hospital usually means no OOP charge for the patient, because the doctor's fee is covered by a combination of Medicare and private health-fund rebates.

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A VMO works for a hospital on a contractual basis and operates a private practice elsewhere; they set their own fee. The VMO's fee for services may be higher than the total a patient would get back from Medicare and their PHI. That extra amount – the “gap” fee – is an OOP expense that will have to be paid by the patient to the VMO.

The revenue gain is characterised by what the hospital would receive from Medicare and PHI when the patient elects to use their PHI versus the cost of care by the hospital in treating a public patient. The opportunity cost is the income foregone from the next best alternative (or only alternative), that is, treating the patient free as a public patient.

\*Note, Canterbury Hospital has a primary VMO-led clinician workforce; there are a small number of Level-1 staff specialist doctors. In accordance with the NSW Ministry of Health's staff specialist determinations policy, the hospital they are employed at is meant to retain 100% of Level-1 staff specialist facility fees (that is, their entire private bill for the financial year that they have remained as a Level-1 staff specialist). For Level 2–5 staff specialists, there is a portion of facility fee that is collected by the hospital in addition to what the doctor would earn from private billing.

According to the SLHD finance department's data, between July 2011 and June 2012, the total revenue for accommodation fees and prosthesis rebate fees was \$2,959,603.43. It is estimated that the total revenue, including the other revenue components listed above, would total approximately \$3.02 million during the 2011/12 financial year. This means that \$3.02 million worth of cost in providing a healthcare service was recovered. If no revenue is collected by the health service, the ability of providing a healthcare service at the local hospitals would be reduced by \$3.02 million, as there is a fixed amount of financial resources available. In other words,

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the revenue collected means that an additional \$3.02 million worth of healthcare services could be provided.

**Total Revenue: \$3,020,000.00**

**Costs:**

**Cost of salary and wages, annually**

**\* Key Assumptions:**

If more than 50% of the estimated percentage of work for the role is related to PHI revenue, then the cost for salary and wages on-cost (salary and wages overhead expenses) is to be included in the cost calculation

PPOs + salary and wages on-cost (1.42 FTE)

Sub Total: \$90,842.47

Cashier (1 FTE, approximately 15% of work is related to PHI)

Sub Total: \$7,801.65

ED clerical staff (2FTE, approximately 15% of work is related to PHI)

Sub Total: \$14,598.36

Revenue manager salary (1 FTE, approximately 30% of work is related to PHI)

Sub Total: \$18,863.10

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Miscellaneous administrative staff (E.g. ward clerks, administrative clerks, clerk procedural unit) (10 FTE, approximately 5% of work is related to PHI)

Sub Total: \$24,330.60

Central finance department staff (3 FTE, approximately 15% of work is related to PHI revenue at Canterbury Hospital)

Subtotal: \$23,404.96

Calculation method: using base salary for each of the award categories above \* the amount of FTE \* the approximate percentage of their work provided relating to PHI \* salary on cost (if applicable)

**Total annual cost of salary and wages = \$179,841.14 (approximately) for 2011/2012 financial year)**

### **Cost adjustment**

\* Key assumptions:

VMOs who provide care to private patients are able to claim the cost of their service directly from the PHI fund and Medicare instead of from the hospital. The cost for the public hospital to provide care to private patients is reduced in this sense, because by contrast, when care is provided to public patients, the VMOs' payment is borne by the hospital entirely. It needs to be noted that the choice provided to VMOs are not in contradiction to the National Healthcare Agreement, as long as the VMOs are not claiming the cost from the hospital and then again from PHI fund and Medicare.

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## **Cost of reduced VMO payment**

Calculation Method: number of admitted private patients in 2011/12 \* estimated 2 service/consultation sessions by the VMO per admission per patient \* average VMO sessional payment cost per consultation = the total VMO payment cost savings (as the cost is substituted by VMO claiming from non-hospital bodies)

Total number of admitted private patients in 2011/12 at Canterbury Hospital was 1745.

During 2011/12, the average VMO hourly payment was approximately \$230.92.

Assume that on average, each VMO's service/consultation session for each private patient lasts approximately 30 minutes (this could be anything from a ward-round based consultation session to surgery). That is half an hour per session and approximately one hour per patient. Therefore, the average cost savings in that financial year would be approximately  $1745 \times \$230.92 = \$402,964.10$

**Total cost adjustment = - (\$402,964.10)** the negative sign means a cost saving

## **Cost of goods and services**

\* Key Assumptions:

It may not be easy to identify the specific cost of goods and services for the purpose of PHI promotion; most costs are estimates only. If other health facilities also incur goods and services costs for encouraging and promoting PHI, this should account for their cost based on the hospital's own cost data.

## **Cost of providing free benefits to patients who use PHI**

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Assume that during 2011/2012, all patients are given a free toiletry pack as a way of thanking them for using their PHI. The contents of the toiletry pack includes small personal hygiene products such as toothpaste, shampoo, mints, a comb, socks, body lotions, etc. Although the toiletry pack is donated by an organisation and therefore not charged to the hospital during 2011/12, there is a need to consider at least the material cost if this supply arrangement ceases and the hospital is the expected to meet the cost. It is estimated that the material cost of this toiletry pack would be approximately \$8 each if purchased by the hospital. The total number of private patients during 2011/12 was approximately 1,745. Therefore the total estimated cost for providing toiletry pack would be  $1745 \times \$8 = \$13,960.00$

**Subtotal: \$13,960.00**

#### **Cost of waiving patient excess/co-payment for single room**

Assume that during 2011/2012, 70% of the hospital's private patients had an excess/co-payment that has to be met by the hospital, and that the average payment is approximately \$250 per patient. The total cost for the hospital to waiver such a cost for patients is approximately 1,745 (total number of private patients during the period)  $\times \$250 \times 70\% = \$305,375.00$

**Subtotal: \$305,375.00**

#### **Cost of providing other free benefits to patients who use PHI**

Apart from the above two benefits, no other benefits (such as free newspaper, free parking, free TV hire) are available at Canterbury Hospital.

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**Subtotal: \$0.00**

Software licensing cost (software applications and services such as Thelma and Eclipse are used to check the PHI status of patients; these products are used by SLHD hospitals); such cost should be apportioned to account for Canterbury Hospital's share.

Assume that the annual share of cost for Canterbury Hospital is approximately \$2,000.00

**Subtotal: \$2,000.00**

**Cost of creating/printing of pamphlets, posters, thank you letters and other promotional material**

Assume that the share of cost for Canterbury Hospital per annum is approximately \$3,000.00

**Subtotal: \$3,000.00**

**General stationary cost (poster frames, printing of election forms, postage, etc.)**

Assume that the share of cost for Canterbury Hospital per annum is approximately \$2,000.00

**Subtotal: \$2,000.00**



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**Cost of IT equipment/telecommunication (PHI election related)**

Assume that the share of cost for Canterbury Hospital per annum is approximately \$3,000.00

**Subtotal: \$3,000.00**

**Cost of preparing an educational program for staff (regular staff in service, orientation, catering)**

Assume that the cost of preparing such material for Canterbury Hospital per annum is approximately \$10,000.00

**Subtotal: \$10,000.00**

Calculation method: Sum of the above cost of goods and services components

\$13,960.0 + \$305,375.00 + \$0 + \$2,000.00 + \$3,000.00 + \$2,000.00 + \$3,000.00 + \$10,000.00

**Total cost of goods and services: \$339,335.00**

**Net cost/revenue**

Calculation method: Net Revenue = Total revenue - (Total cost of goods and services plus or minus cost adjustment)

= \$3,020,000.00 - (\$179,841.14 + \$339,335.00 - \$402,964.10\*)

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**Net revenue = \$2,903,787.96**

\*VMO sessional fees saved by hospital

Return on investment (ROI) = Net revenue / net cost of investment

$$\begin{aligned}\text{ROI} &= \$2,903,787.96 / (\$179,841.14 + \$339,335.00) = \\ &= \$2,903,787.96 / \$519,176.14 = \mathbf{5.59}\end{aligned}$$

This financial modelling analysis calculated that the net revenue during 2011/12 at Canterbury Hospital was approximately \$2,903,787.96. Further, an ROI of 5.59 has been derived through this analysis, indicating that the investment yielded a return that is 5.59 times more than its cost. This suggests that the investment into encouraging PHI uptake has resulted in a very high level of financial return.

### **8.3. Secondary Data Result And Analysis**

Staff's interaction with patients provides an important communication opportunity between staff, patients and their families on matters regarding financial election and the use of PHI. Their knowledge, understanding and perspective of the PHI cover directly affects the way patients pass on such information to others.

In 2012, a redesign project was undertaken by a number of staff from the SLHD aimed at improving private inpatient revenue at Canterbury Hospital. The project made a number of findings, followed by recommendations that are currently being progressively rolled out within Canterbury Hospital.

Part of the project required the project team to obtain information from staff on what their knowledge and opinions were in relation to PHI and inpatient revenue at the hospital. View and information from staff regarding PHI utilisation were obtained from

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a focus group and the results discussed in this part of the thesis was extracted as secondary data from the focus group result. The focus group was conducted through a nominal technique, where potential solutions are categorised based and ranked where appropriate. It should be noted that the redesign project had explored some aspects of the PHI utilisation issue in Canterbury Hospital, independent of the study covered by this research thesis paper. Some aspects of this redesign project had explored issues that the research thesis also considered relevant. After obtaining consent from the project group, some of the redesign project's findings have also been documented here to aid the current research thesis in strengthening its research coverage and academic rigour.

It is important to note that one of the comments made by a doctor was that, "Some doctors are not aware that the hospital is prepared to cover a patient's excess." This comment indicates a major gap in existing communication and staff education programs on PHI utilisation. It suggests that not only do patients need to be made aware of such arrangements, but staff – especially treating doctors, registrars and clinical professionals – should be even better informed of what is and is not covered by PHI or the hospital's own healthcare funds. These people are at the coalface of clinical services provision – patients and their relatives are more likely to turn to them to ask for information and advice regarding hospital issues (even if those issues were financial). Frequently, clinical professionals are being asked by patients whether using their PHI is a good idea despite having been provided with information by non-clinical staff. If the clinical professionals are not equipped with adequate knowledge or cannot confidently provide information to patients, then this could make the PHI conversion process much more difficult when someone else needs to approach the patient or visitor again.

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Another view expressed by a doctor stated that “If the hospital is prepared to cover the excess for all patients, then they need a clear-cut statement to give to the patients.”

One doctor stated that, “You need to tell the doctors what the hospital policy is for private patients.”

One of the staff members said that, “A fact sheet with the basic facts, not in small print, is needed to explain the use of private health insurance at Canterbury Hospital”

A lot of what the hospital has implemented with regards to PHI have already been covered in the comments above, however, some staff are still not aware. These views above again indicate the large gaps in knowledge and lack of awareness among hospital staff of what the hospital had already done to change the misconceptions around PHI utilisation. It could be seen from these examples that the staff's lack of knowledge in the areas of PHI may be a barrier in providing accurate and trustworthy information to patients regarding PHI utilisation.

“People think that having private health insurance will give them preferential treatment but it only guarantees the surgeon or physician of choice” (VMO secretary 1)

“I could give you more private patients if you could give us a surgery date... There are too many uncertainties” (VMO secretary 2).

Views expressed by the VMO secretaries above indicate that not only does patient PHI knowledge education still need to be enhanced, but that the ability to offer a definitive surgical date could be an important draw card in referring PHI patients to public hospitals. The unique position of the public hospital as both a general elective and emergency treatment centre restricts the hospital's ability to always be definitive

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in offering surgical dates to patients. Therefore, from one perspective, this again reiterates that public hospitals are not competing with private hospitals for private patients; the combination of private and public hospital facilities provide choices and opportunities to patients when deciding where they would like to receive their treatment, and from whom.

Another important aspect shown from the above comments is that the VMO secretaries are very powerful stakeholders in the PHI patient conversion process. They are important communication agents between the hospital and the patients. Although they are not hospital staff, they can in fact influence the patients' decisions about whether or not they go to a public hospital, and if the patient also holds PHI, whether or not they use their insurance for their elective admission. In addition, they could also provide vital information to the hospital about which patients coming to the hospital actually hold PHI.

It is interesting to note that there were many suggestions that hospital staff have expressed in terms of how they think PHI conversion rates can be improved. The suggestions made by the staff offer unique insight into factors that may affect patients' decisions on whether or not to use PHI in a public hospital. For example: "Co-location of a private hospital near a patient's home or near the specialists' rooms may affect their decision to choose a private hospital or public hospital". (Staff) More importantly, these insights offered by staff provide researchers with a different perspective (instead of just patients' experience) of what they consider to be the relevant factors that could affect patients' decision about PHI utilisation. It is relevant to consider the way in which staff perceive matters relating to PHI; their opinions about and attitudes toward PHI may also correlate to the way they advise patients on financial matters.

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It is interesting to note that through the responses obtained as part of the Canterbury Hospital Improvement in Revenue Project (CHIRP) redesign project, it appears that the opinions and attitudes of staff about PHI has generally been supportive. Staff generally understand the importance of what part patient fees revenue (from PHI) plays in the landscape of funding arrangements in public hospitals.

#### **8.4. Impact Of PHI Utilisation**

Findings obtained from earlier part of the result reporting and analysis chapter provide important facts and foundations to assist in understanding a range of aspects of PHI utilisation in a public hospital. This second part of the chapter explores further the financial and economical element of PHI utilisation and attempt to ascertain in a practical sense the impacts on a public hospital.

##### **Private Health Insurance Financial and Economical Impact To A Public Hospital**

According to the 2004–2005 NHS, PHI funds provided 21% of the total non-government health sector funding in 2004–05. Just under half (48%) of this was spent on private hospitals, along with dental services (12%), administration (10%), and medical services (10%). Benefits paid by the funds in 2004–05 were up 7% from 2003–04. An estimated \$626 per insured person was spent by PHI funds in 2004–05 (AIHW, 2005).

The PHI revenue improvement strategies many NSW public hospitals have implemented are generally similar in nature. They aim to attract or convince public patients to use their insurance while still providing patients with the choice of electing to be a public patient. In general, these strategies include visual promotional material in attracting patients' attention, providing information to patients about reasons for using PHI, and some hospitals offer benefits such as: choice of a single room, free

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parking, free patient TV hire, free newspaper, and free toiletry pack to entice patients to show them that there are clear tangible benefits to use PHI. These benefits, while they are practical and offer value from the patients' own perspective, are however usually dependant on individual hospitals' internal policies and are subject to availability.

There are a number of motivators for public hospitals to promote the utilisation of PHI among patients. Firstly, patients who utilise PHI cover for their stay contribute directly to the hospital financially through the increase of inpatient fees revenue. Additionally, patients who use their PHI to increase the awareness of both the hospital staff and other patients about the benefits of PHI utilisation, this in turn may encourage more patients to become interested in using their PHI. For patients, they receive tangible benefits that can even make their decision delivers value to themselves. In some instances they may have altruistic reasons and feel that their contribution of using PHI is assisting the public hospital to continuing to provide a high standard of service. Moreover, patients who use PHI at a public hospital for receiving care from their choice of doctor would value this privilege and may be likely to continue using PHI for future admissions.

It has been estimated that every additional percentage point of private patients in Canterbury Hospital (approximately 20 additional private patients per month) represents a potential \$240,000 per annum in patient accommodation income for the hospital. This estimation is based on Canterbury Hospital's revenue capture performance in December 2011.

The following two graphs (Figure 19 and Figure 20) demonstrate the level of PHI usage from July 2009 to June 2011 and the amount of accommodation income received through patients' use of their insurance.

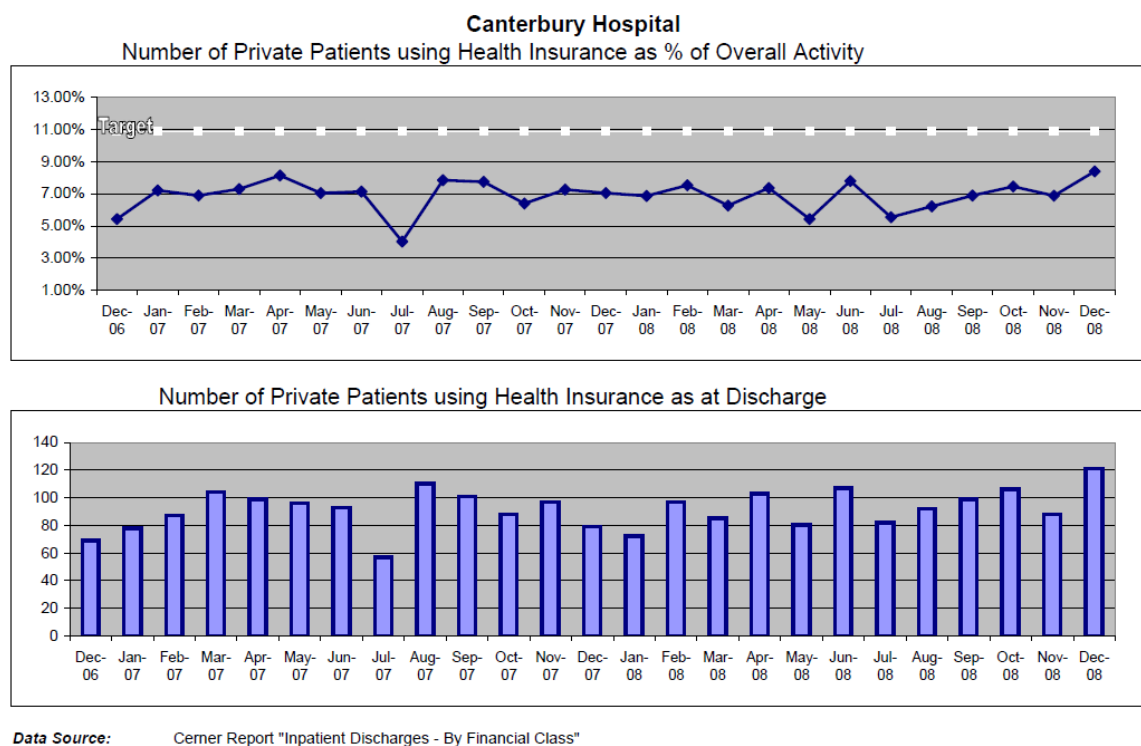


Figure 19. Canterbury Hospital PHI utilisation data. (Data Source: Sydney South West Area Health Service PHI Utilisation Data, 2009)

Fin Year	Canterbury Shared	Canterbury Single
06/07	\$775,225	\$864,387
07/08	\$680,402	\$873,370
08/09	\$873,515	\$690,514
09/10	\$1,024,016	\$1,090,621
10/11	\$1,157,316	\$1,283,243

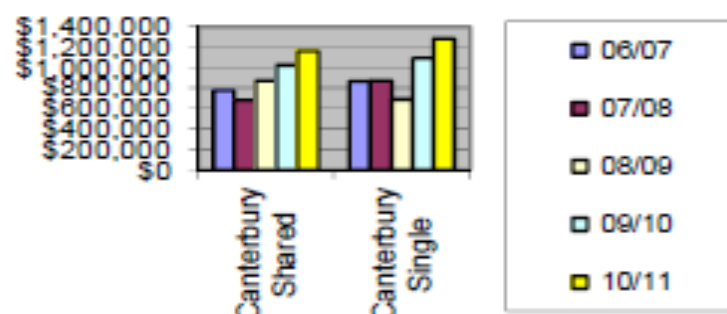




Figure 20. Canterbury Hospital PHI utilisation data. (Data Source: Sydney South West Area Health Service PHI Utilisation Data, 2011) Shared: Shared room accommodation; Single: Single room accommodation

As indicated by Figure 21 below, from June 2009 to June 2011, the percentage of private patient utilisation rate at Canterbury Hospital increased from 8.5% to about 10%; the trend line in the graph shows a steady increase over the two-year period.

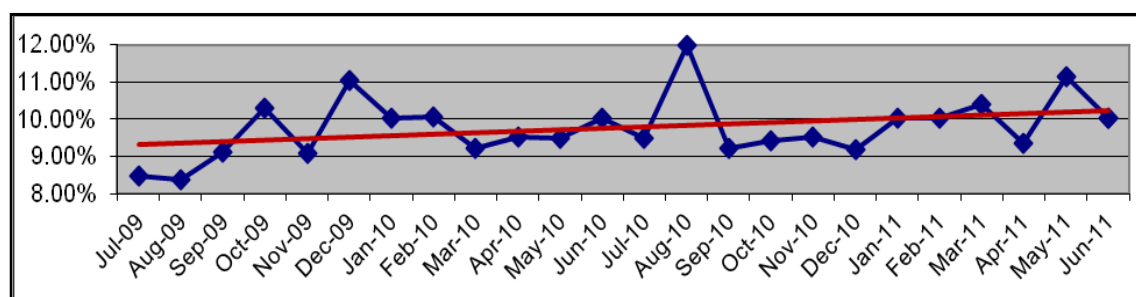


Figure 21. Canterbury Hospital PHI utilisation data (Data Source: Sydney South West Area Health Service PHI Utilisation Data, 2011))

The bar graph displays the amount of accommodation income received through patients' use of their insurance. From the financial years 2009/10 and 2010/11, this graph shows that the patient fees revenue has risen from \$2.12 million to over \$2.44 million – an increase of over \$325,000.

Figure 22 below contains newer data demonstrating changes to PHI utilisation rate at Canterbury Hospital where some additional communication strategies were employed to increase patients awareness of PHI. While there has been an increase in single-room accommodation income, any future increases may be limited by the utilisation of these beds for clinical needs.

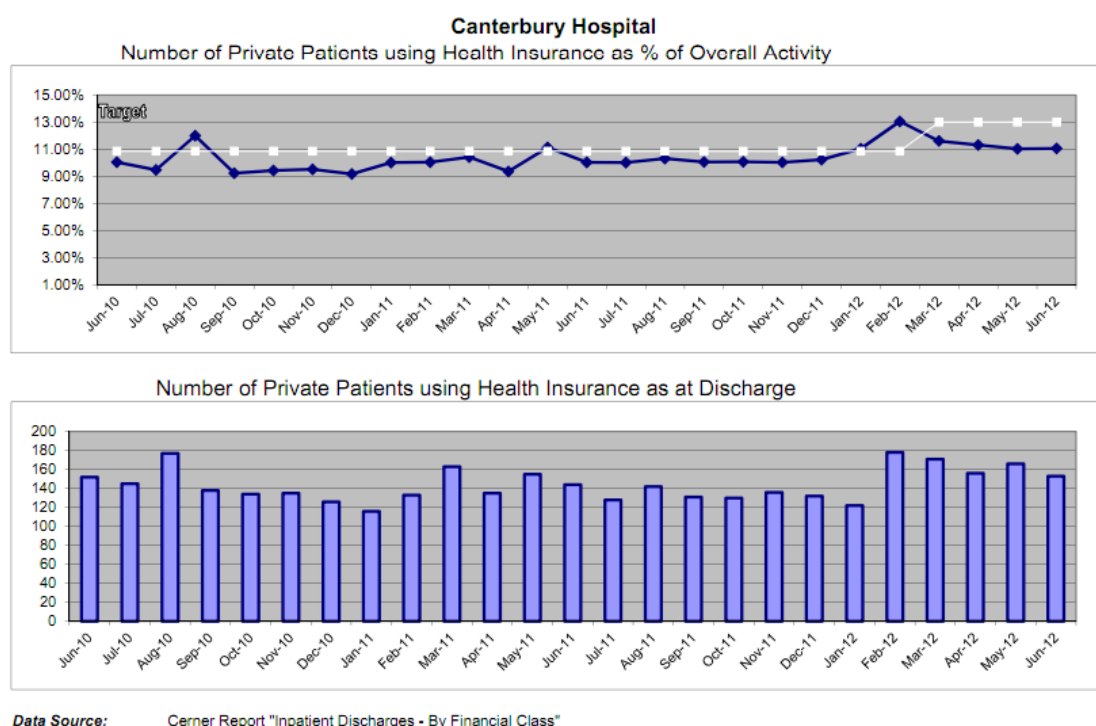


Figure 22. Canterbury Hospital PHI utilisation data (Data Source: Sydney Local Health District PHI Utilisation Data, 2011)

The table below (Figure 23) demonstrates how the PHI capture rate is calculated at Canterbury Hospital. As discussed in previous sections, private patients in public hospitals are generally made up by two major groups; the first group consists of private patients who have entered the hospital via the ED and later been admitted as an EPI; and the second group is made up of patients who entered the hospital via the non-emergency corridor. The total number of private patients is then divided by the total number of hospital separations (a separation is defined as a patient being discharged from the hospital following a course of treatment), which derives the total percentage of private patients at the hospital during a particular month. The indicator for total number of private patients is demonstrated by each private patient's financial classification (as indicated by the health information system) at the time of discharge.

For the private patient rate to be counted towards the current month, the patient needs to be discharged in the current month.

Canterbury							
Month	Total Seps	Priv excl EPI	% Priv excl EPI	EPI	% EPI	Priv	% Priv
Feb-11	1324	17	1.28	116	8.76	133	10.05
Mar-11	1565	26	1.66	137	8.75	163	10.42
Apr-11	1442	23	1.60	112	7.77	135	9.36
May-11	1392	28	2.01	127	9.12	155	11.14
Jun-11	1435	20	1.39	124	8.64	144	10.03
Jul-11	1277	26	2.04	102	7.99	128	10.02
Aug-11	1376	39	2.83	103	7.49	142	10.32
Sep-11	1301	42	3.23	89	6.84	131	10.07
Oct-11	1290	35	2.71	95	7.36	130	10.08
Nov-11	1355	45	3.32	91	6.72	136	10.04
Dec-11	1290	31	2.40	101	7.83	132	10.23
Jan-12	1104	28	2.54	94	8.51	122	11.05
Feb-12	1363	41	3.01	137	10.05	178	13.06
Mar-12	1473	39	2.65	132	8.96	171	11.61
Apr-12	1379	35	2.54	121	8.77	156	11.31
May-12	1505	43	2.86	123	8.17	166	11.03
Jun-12	1383	44	3.18	109	7.88	153	11.06
Jul-12	1487	41	2.76	123	8.27	164	11.03
Aug-12	1578	54	3.42	120	7.60	174	11.03
Sep-12	1436	42	2.92	117	8.15	159	11.07
Oct-12	1455	46	3.16	116	7.97	162	11.13
Nov-12	1449	42	2.90	107	7.38	149	10.28
Dec-12	1330	37	2.78	105	7.89	142	10.68
Jan-13	1249	38	3.04	108	8.65	146	11.69
Feb-13	1455	45	3.09	105	7.22	150	10.31
TOTAL	34693	907	2.61	2814	8.11	3721	10.73

Figure 23. Canterbury Hospital PHI utilisation data (Data Source: Sydney Local Health District Private Health Insurance Utilisation Monthly Statistics 2013)

EPI (Emergency Privately Insured). Under this arrangement, patients who entered the hospital via the ED, and who had later on been admitted as an inpatient, could choose to use their PHI.

There are several factors that may affect the percentage of PHI capture rate at Canterbury Hospital (the similar cases of variation factors are generally applicable for most public hospitals in NSW). These factors include:

- The amount of total separations
  - If the amount of private patients remains unchanged during a month, the higher number of total separations would result in a lower PHI

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capture rate, as the numerator is the same while the denominator has increased.

- On the other hand, if the number of total separations remains relatively steady, when there is a large number of private-patient conversions through either of the admission corridors (emergency and non-emergency) the PHI capture rate would increase, as the numerator has increased while the denominator has remained steady.
- The time of patient admission and discharge
  - As discussed above, the time of admission is less relevant than the time of discharge, in the context of PHI capture-rate calculation.
  - If there is a large number of patient admissions at the end of a month, and the patients are not discharged until the next month, then these private patients are counted towards the next month and not the current month. In other words, although the private patient occupied a bed, because they are not discharged during the month they were admitted, they do not contribute to that month's PHI capture rate.
  - This is also relevant when there are long-staying patients who may occupy a hospital bed for longer than usual; this affects the hospital's capacity to turn over patients quickly and limits the hospital's ability to treat more, potentially private, patients.
- Variation in admission criteria
  - From time to time, the criteria for a patient admission may change due to variation in admission policies or clinical innovations. This could also affect the PHI capture rate. For example: patients staying in the

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hospital's ED and waiting for pathology or diagnostic test results may or may not be seen as an admission depending on the hospital's admission criteria. However, if private patients are only in the hospital's ED for a short period of time and are later discharged, that is still considered to be an admission if it met the hospital's admission criteria. These numbers may not be seen as significant on a case-by-case basis, but if a significant number of patients are admitted and later discharged under such criteria, then the effect that this would have on the total PHI capture-rate may be quite significant.

- Furthermore, the way in which a hospital's ED is designed or expanded could also have a significant impact on the PHI capture rate. For example, Canterbury Hospital's ED at present does not have an Emergency Medical Unit (EMU); this means that some patients who may need to be kept in the ED for further observation or for any other clinical reasons are not admitted as an inpatient to the EMU. Many of these patients may be short-stay patients; however, given that a physical ward increases the hospital's bed base and throughput, then this represents a potential for increased PHI revenue, if these patients are indeed also willing to use their PHI for their admission. This is demonstrated in other hospitals with an EMU, and if the admission criteria warrants, a patient may be admitted to the EMU for a short period (a physically separate ward within the ED) and these short (or "day-only") admissions could represent a significant number of private patients. However, this is also dependent on a number of things such as communication between the doctor and the administrative clerk on the decision to admit, and the time of admission (e.g. sometimes

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when a decision to admit was not communicated to the clerk, then the opportunity to sign up a private patient may be missed when the patient is discharged before being approached by a member of staff).

- There may also be some instances wherein hospitals make certain arrangements with VMOs, and that VMOs see an advantage in bringing private patients to public hospitals or converting existing public patients for booked elective procedures. This could also significantly change the amount of private patients captured.

PHI revenue is generally made up by a number of major components. These include:

- Accommodation fees revenue (the patient bed and room type)
- Diagnostic and pathology fees revenue (pathology and imaging tests)
- Prosthesis rebate fees revenue (orthopaedic and other surgical implants)
- Private patient upfront excess payment revenue (co-payment prescribed by PHI fund)
- Applicable staff specialist private patients consultation fees revenue

There are also several factors that may affect the PHI revenue at Canterbury Hospital (the same case is generally applicable for most public hospitals in NSW):

- The PHI capture rate
  - This is the single most significant factor that affects the PHI revenue

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- Usually a higher PHI capture rate represents a larger potential by the hospital to capture PHI revenue, however, this is dependent on the type of accommodation status that is outlined below
  - Patient accommodation status
    - As per PHIAC, patients who are admitted to a single hospital room often attract a higher accommodation payment by the private health fund to the health service provider than if the patients were admitted to shared accommodation.
    - The ability for public hospitals to maximise PHI revenue depends on the availability of single rooms for private patients. In many instances, single rooms in public hospitals are reserved for patients with the clinical need for separation rather than because of a financial classification indicator. That is, clinical needs, for example, when a patient requires specialised monitoring or when the patient is isolated due to infection control needs, take priority when it comes to which patients are admitted to a single room. However, when single rooms become vacant and a clinical need to accommodate another clinically required patient does not exist, then there are opportunities for private patients to be admitted into a single room, therefore maximising the potential accommodation revenue. It should be noted that the number of private rooms are usually constrained by the hospital's original design, limiting the single-room revenue a hospital could potentially obtain. Usually, NSW public hospitals on average have very high occupancy rates, meaning there is very little idle or empty-bed capacity either in single or shared accommodation. However, single-

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room revenue is only meaningful when it does not compromise clinical accommodation of all patients.

- Fees payable by the health fund
  - From time to time, the amount of fees payable by the health fund for particular types of services may vary, affecting the revenue that may be collected by the hospital. For example, the amount of shared and single-room accommodation fees are increased yearly, and this represents a revenue increase for the hospitals.
  - On the other hand, some health funds may review what type of health conditions that they would cover the patient for, and a variation of their coverage policy and rebate arrangements from time to time could also affect the amount of revenue, or whether any revenue at all is collectable by the hospital.
- Retrospective classification of patients' financial status
  - Each time a patient enters the public hospital system, they are registered on the patient information system with a financial classification code. These codes identify how the patient funds their episode of care; a vast majority of patients who are "public" (non-private) patients are admitted to the hospital via a no-charge public patient financial classification code. Private patients, on the other hand, have relevant financial classification codes indicating whether they are a self-funded or a private health fund patient.
  - Some patients who have had multiple admissions to hospitals in the past and may have been admitted under various different financial



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classification codes due to their admission status, or because they have not declared their PHI policy. On the odd occasion when they have decided to use PHI cover, and if they have held the cover for a long time (during which time if they have been admitted to the hospital before but have not used their PHI), it is possible that these patients could consent for their previous admissions (which were no-charge public financial classifications) to be converted to PHI financial classification, retrospectively.

- Length of stay

- Length of stay (LOS) is a definition that represents how long a patient had stayed in the hospital between their admission date and the date of discharge (Ortiga et al., 2012).
- Generally speaking, from a PHI capture-rate perspective, long length of stay (regardless of whether the bed was occupied by a private patient or not) represents a reduced capacity for the hospital to provide care to patients. This is because the beds are occupied and there are only a fixed number of bed days available, thus reducing capacities for more patients to occupy these beds.
- Also, for hospitals with short-stay ED wards (for example, an EMU) that can cater for relatively short period and less complicated admissions, the capacity for quick patient turnover (admission and discharge) would likely to be higher compared to hospitals that do not have such capacity. Therefore, this could also represent higher patient throughput and the potential for more private patients to use their PHI for their admission.

- However, from a PHI revenue perspective, the longer the LOS for a private patient, the higher the potential revenue for the hospital. That said, an increase in the total patient admission may also increase the numerator in PHI capture-rate percentage calculation.

The data and graph below outlines some of the revenue, or cost recovery effort, that Canterbury Hospital has been making for the past few years. Figure 23 illustrates the total amount of PHI related revenue/cost recovery received by the hospital between July 2011 and February 2013 total approximately \$5.95 million. Figure 24 shows that the same data during the same period in a trend graph, indicating a steady increase of money received during this period. Figure 25 shows that during this same period the total number and percentage of patients using their insurance had increased steadily through various methods the hospital had implemented to better inform patients about using PHI.

#### CASH RECEIVED IN HOSBIL (GENERAL FUND)

FROM JULY 2011 TO FEBRUARY 2013

	CANTERBURY HOSPITAL		
	ACCOMODATION	PROSTHESES	INPATIENT REVENUE RECEIVED
<b>Jul-11</b>	<b>\$227,196.55</b>	<b>\$24,864.00</b>	<b>\$252,060.55</b>
<b>Aug-11</b>	<b>\$285,805.80</b>	<b>\$6,004.00</b>	<b>\$291,809.80</b>
<b>Sep-11</b>	<b>\$300,976.65</b>	<b>\$7,705.00</b>	<b>\$308,681.65</b>
<b>Oct-11</b>	<b>\$307,818.00</b>	<b>\$9,017.00</b>	<b>\$316,835.00</b>
<b>Nov-11</b>	<b>\$225,490.65</b>	<b>\$12,675.00</b>	<b>\$238,165.65</b>
<b>Dec-11</b>	<b>\$256,829.35</b>	<b>\$6,295.00</b>	<b>\$263,124.35</b>

<b>Jan-12</b>	<b>\$204,823.24</b>	<b>\$0.00</b>	<b>\$204,823.24</b>
<b>Feb-12</b>	<b>\$101,830.20</b>	<b>\$2,522.00</b>	<b>\$104,352.20</b>
<b>Mar-12</b>	<b>\$58,400.00</b>	<b>\$34,031.00</b>	<b>\$92,431.00</b>
<b>Apr-12</b>	<b>\$229,053.43</b>	<b>\$3,843.00</b>	<b>\$232,896.43</b>
<b>May-12</b>	<b>\$229,532.59</b>	<b>\$41,317.00</b>	<b>\$270,849.59</b>
<b>Jun-12</b>	<b>\$370,385.97</b>	<b>\$13,188.00</b>	<b>\$383,573.97</b>
<b>Jul-12</b>	<b>\$430,967.90</b>	<b>\$12,721.00</b>	<b>\$443,688.90</b>
<b>Aug-12</b>	<b>\$263,106.05</b>	<b>\$3,411.00</b>	<b>\$266,517.05</b>
<b>Sep-12</b>	<b>\$416,323.75</b>	<b>\$25,208.00</b>	<b>\$441,531.75</b>
<b>Oct-12</b>	<b>\$366,166.60</b>	<b>\$21,721.45</b>	<b>\$387,888.05</b>
<b>Nov-12</b>	<b>\$369,687.40</b>	<b>\$26,096.00</b>	<b>\$395,783.40</b>
<b>Dec-12</b>	<b>\$229,661.20</b>	<b>\$5,203.00</b>	<b>\$234,864.20</b>
<b>Jan-13</b>	<b>\$390,195.68</b>	<b>\$11,838.00</b>	<b>\$402,033.68</b>
<b>Feb-13</b>	<b>\$377,827.50</b>	<b>\$43,689.95</b>	<b>\$421,517.45</b>
<b>TOTAL</b>	<b>\$5,642,078.51</b>	<b>\$311,349.40</b>	<b>\$5,953,427.91</b>

Figure 23. Canterbury Hospital PHI revenue financial data (Data Source: Sydney

Local Health District PHI Revenue Data, 2013) Cont.

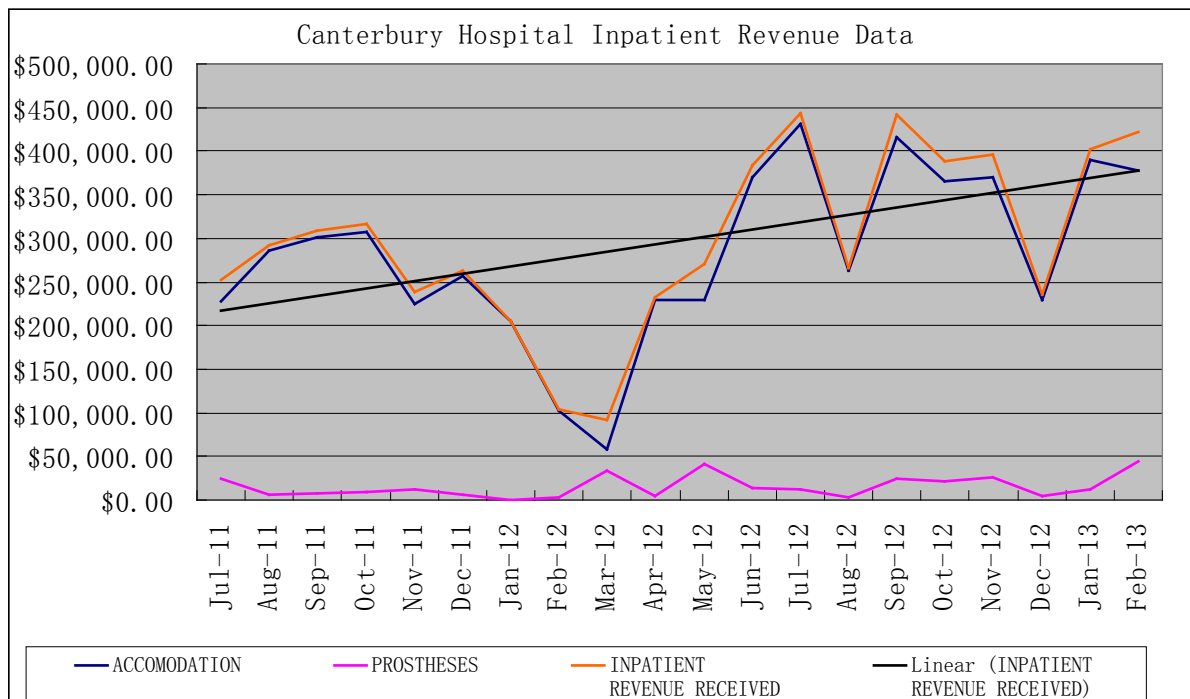


Figure 24. Canterbury Hospital PHI revenue financial data (Data Source: Sydney Local Health District PHI Revenue Data, 2013)

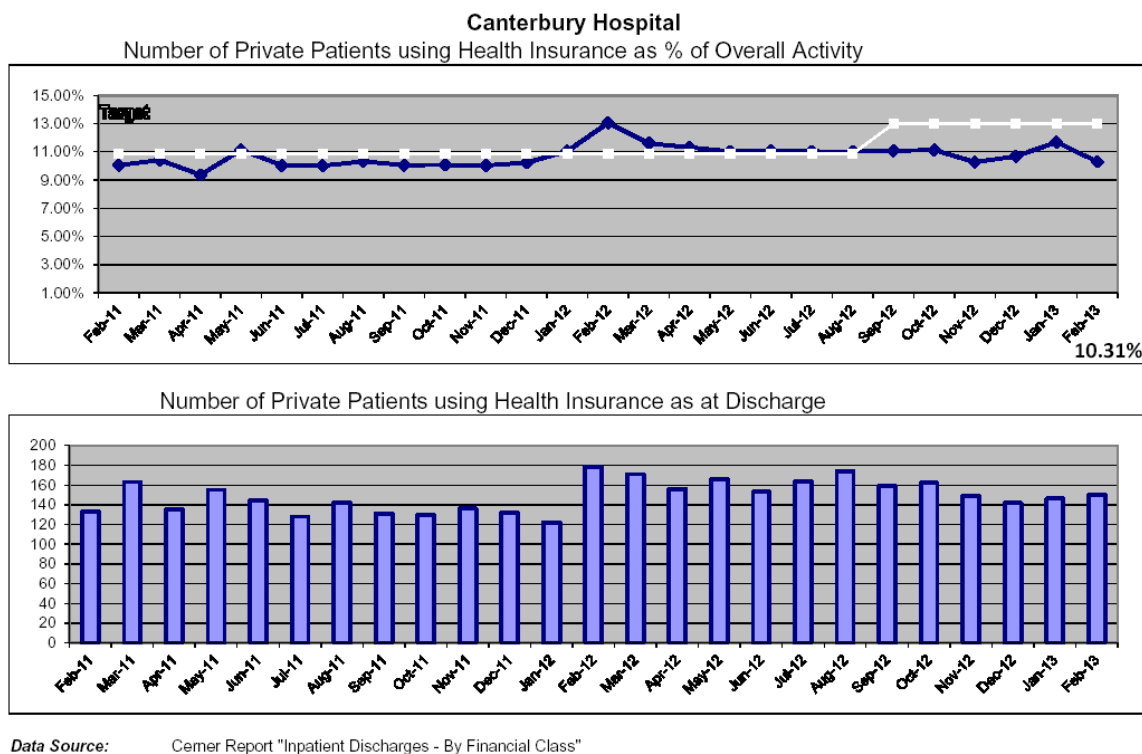


Figure 25. Canterbury Hospital PHI revenue financial data (Data Source: Sydney Local Health District PHI Revenue Data, 2013)

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The results and analysis chapter provided a detailed record of the results obtained through this research from the survey, financial modelling and secondary data. A number of major findings were made in this chapter including factors affecting patients' decision on declaring and using PHI, the financial impacts of patients choosing to use their PHI and hospital staff's view, action and their impacts on patients' decision on PHI utilisation. A further review on the impact of PHI utilisation in practice has also been conducted by examining the patient revenue related financial data obtained at Canterbury Hospital. From the data obtained it is visible that the effort a public hospital had put in to encourage patients to use their PHI has resulted in substantial cost recovery from patients who hold PHI and have used them for their admission.

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## 9. Research Gaps & Limitations

### 9.1. Future Research

This thesis is entitled “What are the factors that influence a patient’s utilisation of private health insurance in a public hospital? What are the impacts of using private health insurance?” Earlier sections of this thesis stated the scope of what topics it intended to cover.

The paper investigated a range of motivations that influence patients’ decisions about whether or not to use PHI in NSW public hospitals. The findings guided further investigation into the impact of PHI utilisation, explored the implications for public hospitals, and provided directions on what and how future strategies could be employed to improve PHI revenue. The paper did not attempt to discuss any topics outside this scope in detail. However, several other issues explored within the central topic areas warrant further investigation.

One could argue that the single hospital-based study presented in this particular paper may be somewhat limited, as Canterbury Hospital itself is only one component of the much wider healthcare system. Although this thesis outlined some useful findings that could be applied to a wider reference group, each hospital has its own unique population catchment, and there are different methods for capturing private patients. However, as the principle of PHI revenue and patient conversion is somewhat similar in public hospitals, the value of looking at the impact of decision-making in one hospital can represent some degree of learning that can be generalised to other instances. That said, one should be aware that each hospital’s population is different; it is advisable that each hospital wishing to apply these findings accurately should collect some baseline data by using the research tools

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outlined in this thesis and modifying them to suit the target hospital's own conditions. Furthermore, as mentioned in previous sections, Canterbury Hospital's local catchment area has a relatively low socio-economic status. Generalising the findings from this study to other hospitals with different local socio-economic statuses and population statuses may need to be executed with caution.

It has been discussed in previous sections that there is a range of typical risk concerns associated with services, and in this case, particularly with healthcare and PHI utilisation. Some strategies were also discussed that could be used to address the risk problems. These risks include areas such as: functional, financial, physical, psychological, sensory, social and temporal risks. Future research studies would benefit by gaining a more in-depth understanding of how these risks (which may or may not be always within the control of a public hospital) affect patient decisions about PHI utilisation.

## **9.2. The Cost-shifting Argument**

Some scholars may take a critical view of this thesis and conclude that some aspects of the paper support cost-shifting in public healthcare system funding, which may, in some people's view, only provide temporary benefits to the current system by shifting costs between the State and Federal funding bodies. Cost shifting in the health care system takes many different shapes and forms, apart from cost shifting between the State and Federal funding bodies, there is also the shifting argument between primary and secondary sectors, also between public and private sectors. The opportunity to explore motivations behind people using their PHI cover is done as a means of helping to show the benefits of supplementing the cost of service provision in public hospitals, as the growth in demand for healthcare services will eventually render the purely government-funded public healthcare system

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unsustainable. It should be noted that the introduction of PHI in Australia was originally intended by the Federal Government for private hospitals to play a more active role in providing health services to Australians, however, private hospitals' eventual cherry-picking behaviour was instead directed at maximising revenue and reducing operational costs (O'Loughlin, 2002). Typically, private hospitals provide treatment to ailments where they aim to obtain the highest PHI payout at the lowest operational cost possible (Wright, 2006). There are a very limited number of private hospitals in NSW with an ED, and the majority of patients would prefer to have had their emergency health conditions treated in a public hospital rather than in a private hospital, simply due to the availability of a public ED (Sundararajan et al., 2004). No matter how successful the argument of cost shifting may seem, the private and public healthcare service provision structure in NSW has already determined that such a shift would likely have very little impact on the general condition of health funds' earnings and private hospitals' profits. Instead, given that the whole healthcare system is under pressure due to increased demand, focus should be placed on how funds can be pooled to provide care to patients instead of how financial resources are manipulated.

A major objective of the thesis is to determine motivations behind why people choose whether or not to use their PHI and find ways of getting more people to choose to identify their admission as a private one, thereby alleviating the funding pressures on the public healthcare system. It should be noted clearly that the national PHI scheme existing in conjunction with the free Medicare scheme is an indication that both systems are legitimate sources of funding healthcare in Australia. Taking a progressive view in this matter, with the ever-increasing cost of healthcare in Australia, the funds that people contribute to both systems in the form of the Medicare levy and PHI premiums are both valid ways of funding healthcare services.



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## **Validity of decisions**

There is the possibility that patients who made the decision not to use their PHI in a public hospital may have been making legitimate and appropriate choices based on their beliefs, views and information available. While experiences of patients in a public hospital may be different from those of patients in a private hospital, it is acknowledged that patients would be more likely to consider using PHI in a private hospital than in a public hospital, because Medicare does not cover private hospital stays. In this instance, it is not to say that one decision is valid and another is invalid, but simply that it is a decision made based on the reasons established and believed by an individual. However, this thesis attempts to understand such rationale in a public hospital setting. It should be noted that this thesis does not attempt to express an opinion that not using PHI in a public hospital is an invalid decision. Furthermore, people may still hold communitarian views about PHI, and may therefore be apprehensive about using their PHI in a public hospital, despite many promotional materials telling them that PHI utilisation is a positive thing, even though this decision may not be viewed as rational in light of the evidence.

### **9.3. Question Of Scope**

It should be noted that this thesis specified clearly its scope, as well as what areas it would not cover.

It is recognised that there is inherent room for improving the value delivered to the community by the vast amount of resources (money, skilled personnel, special materials) expended on healthcare; however, given that the thesis had a defined scope of focus, other topics not related to the core theme are not discussed.

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As mentioned at the beginning of the paper, the Australian system for funding healthcare is not without its problems. The birth of the Medicare system was not a cure-all solution for the problems in existence at the time of its introduction. During the evolution of the nation's healthcare funding system, problems related to the Medicare system began to appear, and PHI gradually became more and more relevant in the current funding context.

Some may argue that the Medicare system was the best solution in that it would be accepted by the Australian Medical Association and other private health-industry operators whilst delivering the primary purpose, which was to provide healthcare that did not carry the risk of bankrupting the patient or their family (as was previously the case in Australia and elsewhere in the world). One could argue that other developed countries have developed relatively sustainable systems that provide unified funding and delivery systems that avoid cost-shifting pressures, which encourages the search for answers to be fundamental health funding system problems rather than continue the cost shifting argument between funding sources. As explained previously, the hybrid private and public funding system dually supports the healthcare system, and this thesis focused squarely on the decision rationale by individuals of whether or not to use their PHI rather than analysing whether or not the private funding system is better than the public system, or vice versa.

#### **9.4. Possible Further Improvement**

There are usually two major components in any study:

1. What is the nature of the phenomenon being studied (a qualitative evaluation of what is being observed)?

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2. What is the numerical importance of the different qualitative issues that have been identified (a quantitative estimation process)?

Usually the research should be conducted by following the two components in that order. For a psychological decision issue such as the one being studied here, the interest is in what people are thinking and what is determining their behaviour. There could be questions raised regarding this research as to whether the quantitative research was conducted before the qualitative research, thereby defying the traditional research method. However, it should be noted in the earlier part of the paper that the research tool was constructed based on the researcher's understanding of the topic combined with the literature review of relevant topics previously examined by other scholars. In other words, the qualitative research about the phenomenon in general has been described previously through the researcher's own eyes, and combined with the view of other scholars, such information that has been made available was useful in constructing the survey tool. In this thesis, the qualitative research is in fact part of the study, and quantitative data can be further explored and clarified by the responses provided by participants. So the process undertaken, although conducted in a different order to what scholars might have seen previously, it is, however, suited to the research in this instance.

Qualitative research (in the case of this particular study, where some qualitative components are included in the survey, see Appendix 3) are normally conducted by trained surveyors or interviewers, with that training aimed at reducing biases that are known to be introduced by the prior beliefs and attitudes of the surveyors/interviewers. It should be noted that although in an ideal research situation, it is best for the person conducting the study to be someone who is not related to or affiliated with the subject organisation, it is not often possible due to resource and

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practicality constraints. In this study, the most optimal compromise was to have the administrative officers who work in a different section of the hospital to survey patients. The surveyors have been trained in the details of how to conduct the surveys and have been given specific instructions on not to interfere with the patient's survey completion process. Part of the survey tool itself contained an information coversheet explaining the impartial nature of the survey itself, advising the participants that the survey does not in any way affect their treatment, and that their identities remain confidential.

It is hoped that through these mitigation strategies, any surveyors, even if they do have a vested interest, either on their part or because they are employees of an administration with a vested interest in a particular outcome, do not in any way affect the impartiality of the study itself.

It should be recognised that the surveying process was a very delicate and sensitive interaction. This study targeted are patients but wanted specifically to identify rationale behind why some patients behaved in the ways they did. Although lots of strategies were put in place to minimise any bias from the surveyor or the participants the fact that the surveyor is an employee of the hospital may have affected the way in which some patients answered the survey. For example, some patients may have found themselves uncomfortable and unhappy to be involved as a patient in a survey that was being conducted by a staff member of an organisation that he/she has been receiving treatment from.

The characterisation of the financial modelling as a hypothesis-free exercise in this study may seem odd against due rigour. Usually, financial modelling involves at its heart the construction of a mathematical equation. That mathematical equation is fundamentally a series of hypotheses and value judgments: what is the balance

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between what costs and what benefits; who pays those costs and who receives those benefits. Econometric analysis has now become a well developed field of statistics, it is about being objective, scientific and getting the best predictors. In the commercial and business world, this might fall within acceptable ethical behaviour, but in the context of healthcare, it is required that a researcher is transparent in their work. In health economics, it is normal to explain one's point of view and to discuss the alternative positions of other actors in one's scenarios.

To explain the financial-modelling context of this research, one needs to refer to the very nature of health funding arrangements in Australia, and the co-existence of the free Medicare system and the user-paid PHI system. In earlier sections of this thesis, the ways in which PHI funds relate to their universal free public healthcare counterpart, as well as how they interact with each other, have been discussed. Duckett (2005b) suggested that both the Federal Liberal and Labor governments over the years through their political actions have, in varying ways, supported the funding of Medicare and the development of PHI in co-existence. This thesis is set in the context of that shared funding arrangement, and an explorative view was taken in order to gain an understanding of patients' decision-making process in relation to PHI utilisation in a public hospital. The financial modelling employed in this thesis focuses solely on the revenue projection for the case-study public hospital, and it does not imply any political agenda or argue the right or wrong of any particular funding strategy. In reality, the nature of health funding in Australia represents the growth and burden of the economy; health service managers are faced with some important decisions relating to how to best ensure that the public healthcare funding arrangement is sustainable.

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## Possible improvements – Questionnaire

Like any type of research tool, it is likely that the tools employed in this study also have room for improvement in terms of enhancing their accuracy and thus their ability to more precisely capture the required information. In relation to the questionnaire itself, there are several technical areas that could be improved upon:

- a) Usually the most rewarding way of structuring a questionnaire is to have a series of stem questions with a series of options (several for each stem), with an ordinal scale for each of the options: this allows each patient to provide their own control, comparing the relative strength of attachment that the patient has to each option, which can then be added across the entire survey population, evidence provided in the structure of the actual questionnaire itself demonstrates that such a consideration has been made. This methodology increases the power of the study, and the repeated measures analysis provides internal calibration of responses;
- d. For the questionnaire utilised in this particular study, some of the survey questions may have several possible answers; when these questions have nominal scale options, these options are not placed in any particular order. This is so that the answers to any of the questions are not structured in any biased way, and respondents are not “lead-in” in answering in any pre-conceived sequences, for example, this is especially the case in the question aimed at capturing information about the factors that have influenced patients’ decisions around purchasing PHI. The relevant answers are organised as options provided to the respondents; however, they are not placed in any

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specific order. There is a chance that these questions and answers could be improved through re-organisation, however, it is probably not entirely possible to eliminate the problems of lead-in questions or bias, as these questions have to be laid out in some sort of order.

- e. It should be noted that this procedure is intended to capture the factors listed, but may lack some efficiency as the order how these options are listed may influence how people answer the questions. However, this could be an endless argument, as the way in which the answers are listed may be influenced by the author's biased view. It is not entirely possible to eliminate bias completely in whatever sequence the possible answers are listed. One remedial action employed when using this survey tool was for each of those questions that presented nominal scale options to be given an "other" option, so that the participants could provide other applicable answers.
- f. Prior to the survey, it is envisaged that the proportion of participants responding to the survey would be high, as the people involved in assisting with distributing the survey could provide assistance to the participants, if required. However, it should be noted that there are still a number of patients who may not have been able to complete the surveys due either to their poor physical condition, mental state or general unwillingness to participate. These variations could affect the reliability of the generalisability of the survey results. One possible solution for minimising the effect of errors could be to engage more surveyors in liaising with participants during the survey, providing a more personal approach and thus increasing the response rate. In this

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study, people who did not answer the survey were not counted – only data for people who completed the survey was used for data analysis.

- g. It is recognised that in an ideal situation, this type of study should be conducted by an entirely independent research team. The use of routine hospital personnel may raise the question of reliability and biased influences. However, given the amount of survey results, the complexity of the study and the resource constraint, the engagement of hospital volunteers in the study was the most optimal option.



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## 10. Contributions, Applications & Future Directions

This thesis outlined a research conducted for investigating issues affecting the utilisation of PHI in a NSW public hospital. The research had a set of research aims and rationales. The thesis elicited the background to the research through an extensive literature review, explaining the reasons for this new study and discussing in detail the research methodology. There is also a chapter reviewing the research feasibility and ethical considerations that are concerned with the research. Evidence presented in this thesis indicates that there is particular relevance in conducting an empirical study in this field. It is important to verify the validities of theories through the results obtained from empirical studies. This chapter explores issues beyond the research result itself and looks at the possible contributions and future applications of the findings. It is then useful to look at what future directions these findings can lead to in terms of further research and practical application.

Understanding the decision-making process of patients, and knowing what factors influence their decisions, could expand the knowledge of health service providers. By increasing the knowledge around the financial impact of patients using PHI in public hospitals, health managers are able to make better-informed decisions about cost and resource utilisation. There could be a number of possible contributions and applications from the findings of the study:

- It informs health professionals of the fact that they play a role in influencing patients' decision-making process with regards to whether or not to use PHI in a public hospital. The health professionals are also better informed about why there is a need to encourage patients to use PHI.

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- For health-service and hospital managers, the health service could use the findings from this thesis to develop relevant training and education material to staff and managers on improving PHI utilisation. This training and education material would use the understanding from this study to focus on the salient PHI utilisation issues, and increase the material's effectiveness.
  - To inform policy makers and enhance the general knowledge in the areas of patients' decision-making process when deciding whether or not to use PHI for their healthcare. This could assist policy makers in developing better health funding policies that help with improving the sustainability of the nation's universal healthcare system.
  - For academics and practitioners gain an understanding of the issues raised by scholars of the impact on health services of the Federal Government's PHI policies, and how these policies are perceived at a hospital level by patients.

There are strong potentials for applying the results and learning gained from this study for future use at Canterbury Hospital. This learning can also be extended and applied to other healthcare facilities within the LHD or other hospitals in the state. Realistically, the findings of the proposed research will only be able to be applied with more relevance if baseline data is established by running the questionnaire in the designated target site. There can be a range of assumptions of what the likely outcomes could be, however the application of these findings would be closely determined by the findings and the local conditions at the target site.

A range of stakeholders would likely be involved in future studies. They should include hospital staff of various professions, patients and their families, PHI

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companies and the LHD. For example, these types of study are likely to identify reasons as to whether or not patients would choose to use PHI; to hospitals these types of findings are useful due to the fact that they generate useful insight in understanding the patient's psychological behaviour, thus enabling them to tailor solutions aimed at achieving specific goals. The financial modelling on benefits to the hospital can also demonstrate to the stakeholders what impact their choices are having on both themselves and the hospital. The findings of this current study could lead to changes to the ways benefits are provided, or types of benefits on offer, and how PHI messages are communicated in public hospitals. Policy changes and tax incentives have been created by the Federal Government in order to combat the rising cost of healthcare, and to alleviate the pressure on the public healthcare system. When there is a significant portion of patients with PHI still choosing to use the public Medicare system, it reflects a clear disconnect between policy intention and reality. One of the important aims of this study was to uncover ways of how to ultimately increase the PHI capture rate of public hospitals in order to help the public healthcare system to realise the benefits of government policies in increasing the Australian population's PHI uptake.

However, the application of the findings in this study is not without its challenges. When health resources become more and more precious, any recommendations that are proposed as a result of the findings should be carefully thought through if they involve additional resource implications. Additionally, the study's findings could potentially impact the way in which patient revenue is captured and calculated. This would potentially have an impact on the hospital's financial position.

In summary, findings of this study would likely have useful applications in practice. This research topic has important utilisation for public hospitals in understanding why

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some patients choose not to use PHI in a public hospital, and considering strategies for encouraging more patients to use PHI. In addition, the study also provides insight into on reasons as to why patients choose to purchase PHI in the first place, thus offering an understanding of their psychological decision-making process. Lastly, the study revealed the financial implications for public hospitals in encouraging more patients to use PHI in order to determine the effectiveness of current practices and provide guidance for strategies in the future. More importantly, future replications of this study can be conducted in SLHD facilities; future studies should aim to sample a large group of hospitals' inpatient populations in order to improve the representation and generalisation of the sample. Findings and outcomes of these studies have the potential of being applied to all hospitals within the SLHD, or across the facilities within NSW Ministry of Health.

Conducting an extensive literature search in preparation for this thesis, and reflecting on the empirical study conducted at a NSW public hospital as part of the current study, a number of findings were revealed. These factors could affect the PHI capture rate and revenue relating to PHI utilisation and conversion.

These findings serve as important points in guiding the discussion of possible recommendations that may potentially assist developing strategies that can help improve the PHI conversion rate in NSW public hospitals. It is essential to note that the findings and the associated recommendations are based on the discussions in earlier sections that health funding by State and Federal Government alone is neither adequate nor sustainable in the long term. The role that the PHI scheme could play as another means of bridging the health-funding gap in Australia cannot be ignored. This is why the central theme of understanding the motivation behind patients' utilisation of PHI, as well as the promotion of utilisation, is so important.

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Thus, the discussion of the series of findings and recommendations focusing on improving PHI conversion rate will occur in this chapter.

Also as part of this chapter, the thesis referred to the research findings above and outline some possible methods for how PHI utilisation rate increase and associated PHI revenue increase could be achieved. These include a range of methods which are categorised in several distinctive groups.

### **10.1. Promoting PHI Utilisation**

Promoting PHI utilisation means communicating the PHI concept and any related information to all patients so that patients can make an informed decision about whether or not they would like to use their PHI. The term “communication” in services marketing is sometimes referred to as the sharing of a meaning and communicating a common understanding.

It has been said that:

External communications channels must be coordinated, as with physical goods, but both interactive communication channels must be integrated to create consistent service promises. To do that, internal marketing communications must be managed so that employees and the company are in agreement about what is communicated to the customer.” (Zeithaml & Bitnerz, 2006, pp.487–488).

This concept is very relevant to what the public hospital needs to do if it is to increase patients’ awareness of PHI and encourage them to use it.

According to marketing theorists (Zeithaml & Bitnerz, 2006), marketing communication is used to:

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- Inform customers about an organisation and its services, and the value offered by the service provider;
  - Persuade customers that a specific service product offers the best solution to a customer's needs;
  - Remind customers of service-product availability and motivate them to act;
  - Incentivise and reward repeat and loyal patronage.

In the public hospital PHI context, marketing communication (or “promotion”, as it is often referred to) may play the role of some of the functions listed above, but not all. For example, communication can be used by the public health organisation to inform customers about the incentives and benefits and offerings available to patients who use their PHI.

Promotional messages about the benefits of using PHI do also, in a way, help customers evaluate offerings and highlight differences that matter to them.

However, communicating service benefits to customers can be challenging when offerings are intangible, particularly in a health setting. Healthcare service is a very typical example of an intangible service, in that people cannot actually see or touch what the service offering is. Services are usually fairly abstract, and there is no one-to-one correspondence with physical objects. There is also the aspect of mental impalpability; people who have experienced healthcare service by a particular service provider before, have better understanding than someone who has not experienced the service at all. The experiential nature of the healthcare service means that messages encouraging patients to use their PHI could attempt to promote the benefits of using PHI, while at the same time provide information to assist patients in making informed decisions on their financial choices.

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**Possible strategies:**

One of the possible PHI-promotion methods could involve photographs and displaying to consumers typical customers in the act of benefiting from the service (in the case of PHI, how both the hospital and individuals themselves would benefit from patients using PHI). It is also possible to obtain and present customer testimonials about PHI experience. Present a vivid documentary on the step-by-step service process. Present an actual case study of what the organisation has done to help a specific client, or a case study of the service experience of a particular patient. For example, present an articulate narration or depiction of a customer's subjective experience through PHI election, and the benefits that they have enjoyed.

Due to the heterogeneous nature of healthcare services, some patients may want to reduce risks by being treated by a particular doctor they know and trust, thus reducing their risk of uncertainty. Promotional methods by the health-service provider should also include information about options that enable patients to choose their own doctor when using their PHI.

It should be noted that in Money Magazine (2013), a patient had written a letter of the month pertaining to her experience of using PHI for a public hospital visit. In this letter, the patient shared her experience of using PHI for a surgical admission when giving birth. The patient was very grateful to the hospital that she paid no more than \$500 in PHI excess fees, and that the hospital took care of any OOP medical costs she may have otherwise incurred. Additionally, the patient felt that the small "gifts" or "added extras" that she received during her stay, such as coffee vouchers, chocolates and wine, as well as a TV and a single room, were, in her opinion, very worthwhile benefits of using her PHI. The patient was clearly very happy about the care that she received. Another notable point from this letter was the patient's

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understanding that because she used her PHI to fund her hospital stay, not only did the hospital receive accommodation fees from the health fund, but these fees could then be used towards purchasing equipment, funding research, and ultimately benefiting the community. Finally, the patient was happy to attest to her stay and encourage other readers with PHI to use it when admitted to a public hospital, and ask for similar arrangements to those from which she had benefited. It should be noted that every patient's PHI cover conditions differ and the way how public hospitals treat excess payments also differ. However, the \$500 the lady paid an excess fee, which in most circumstances is waived by public hospitals in Sydney Local Health District. However, should the patient elect to use her PHI in a private hospital, the excess fee is definitely payable.

It is clear that such patient testimonials have a powerful effect in enabling other patients or potential patients to relate their situations with those of the reviewer. This personal storytelling reduces the anxiety for patients if they do not know much about PHI, and such communication bridges the information gap.

### **Frontline staff engagement, training and education**

- PPOs and revenue managers, who spend most of their time interviewing patients, providing information about PHI and converting patients, would usually know which interview techniques are most effective, depending on the patient profiles. Interview methods that are proven by results should be promoted and practiced and transferred to other hospitals so that all can benefit.
- “Frontline staff” in this thesis refers to both administrative and clinical staff who provide service and medical care to patients and their relatives directly.



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- These frontline staff play a critical part in the process of providing information, thus encouraging and facilitating the PHI utilisation process. Engagement of these staff would be likely to help to improve the effectiveness of communication and increase patients' knowledge of PHI.
  - On top of the existing promotional methods, hospitals should continue to run staff workshops and promote discussions about PHI. The use of PHI should be part of these agendas to increase all staff awareness and make the ownership of this issue everyone's responsibility. Staff ownership and the reiteration of the same mantra can set the constant PHI theme among staff, and knowledge retention can and should continue despite staff turnover.
  - Compulsory workshops/in-service sessions, run by experts in the district finance department, who would be able to answer questions related to PHI, should be held regularly. These face-to-face sessions are usually seem to be more valuable than a one-off e-learning course that is currently available to all staff within the district. This is because these sessions can be customised for procedures and processes at each hospital, and provide opportunities for staff to be involved in decisions and discussions regarding PHI during each session, on an ongoing basis.
  - Organise lunch or morning tea for staff when progress has been made on the hospital's PHI utilisation rate, to reward staff for their work in this area and positively reinforce the result that has been achieved. However, these reward lunches or morning teas should not come to be seen as the sole goal of increasing PHI utilisation. Instead, these would be a token of encouragement and recognition of the staff's positive work.

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- For new staff, there should continue to be orientation programs that are tailored for them. A possible suggestion for enhancing such programs could be that the programs may include presentations related to PHI, and teach new staff how they should be responding to patients and their relatives when it comes to PHI matters. An orientation program that aims to promote PHI benefits and procedures of PHI election should target all new staff, both clinical and non-clinical, doctors especially. Current set up of EPI and PHI financial classification should be clearly communicated so that they understand why and how these arrangements are made. These programs may need to be integrated with training for financial awareness or financial management, helping to increase the awareness of the PHI principle and why it so important in providing supplementary financial resources to health services funding. The training program should not be authoritarian in dictating instructions to staff, rather it should include accurate and useful information in guiding staff communication with patients and patients' relatives about PHI.
  - Champions, who are also clinical professionals, provide care and treatment to patients at the coalface and understand the PHI-related matters, and are happy to influence others in the workplace, could take a leading role in communicating to their colleagues and patients about the benefits of using PHI.
  - For certain frontline departments/services where their work activities relate closely to patients' finance-relate decision-making process, there could be a standing-item agenda to include PHI issues as a key topic in departmental meetings. This item should be aimed at discussing methods of improving PHI

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capture rate, finding new ways to allow patients to use PHI, and ways to demolish barriers to patient PHI election.

### **Staff training and patient engagement**

- Development of educational/promotional packages for staff to include items such as:
  - Provide information to staff on how the revenue raised from patients using their PHI is used. By making the results of the staff's work tangible, staff would be able to relate these to their work effort and achievements. This would provide some form of ownership to staff on the identification of private patients and the collection of PHI revenue.
  - Give information on how the improved revenue affects staff; for example, what is in it for them, if they promote PHI utilisation, as both staff members and community members. Such information is aimed at allowing staff to understand the positive impact of PHI revenue and communicate this positive impact to a much wider community via word-of-mouth.
  - Additional information should also be provided to staff on how using PHI benefits the patient. An information package in clear and succinct language should be distributed widely to staff, and could include such as:
    - Posters and information brochures for staff and patients explaining benefits and incentives offered to patients for using their PHI;

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- Communicate with patients honestly and highlight any OOP expenses and any other expected issues (i.e. inform patients of all financial risks that may be involved). Ideally, processes should be implemented to address these risks and produce guarantees or information about how to minimise these risks;
  - The contact person for seeking information relating to PHI election, and if patients receive bills they do not expect, or wish to obtain further information about their financial decision. This information is important in reassuring patients that their decision making is supported, and risks can be minimised by talking to staff who have intimate knowledge of the PHI system;
  - Information on what incentives exist for patients who choose to use their PHI. Such information should be made clearly visible. Results from this research identified that there is a significantly large amount of people who choose to use their PHI because they would be assisting the community, and some also choose to do so to benefit themselves. Incentives and benefits should be made clear, whether they help the individual patient themselves or the hospital and the wider community.

### **Educating staff about PHI**

- Ensure all staff are aware of who to refer to when they need to ask questions about PHI. PHI is still considered to be a relatively

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complex issue, and there are certain situations that it would require specialist knowledge to understand and explain.

- The positive effect on the hospital of patients using PHI should be made clear to staff. For example, any extra equipment purchased through additional patient fees revenue should be highlighted to staff. This way, staff can see the direct outcome of their PHI-related work and thus relate better back to their effort. When staff are the direct beneficiary of such PHI-capture efforts, they are more likely to strive to encourage more patients to use PHI.
- However, instead of relying only on staff to refer patients to specific staff members with specialist knowledge of PHI, or always contacting the finance department, it would be useful to develop scripts for staff to help them answer basic questions regarding PHI. This would help to reduce patient anxiety and increase staff confidence in matters concerning PHI election.
- Feedback to staff and patients about what the PHI revenue funds are spent on; such information provides staff with the sense of ownership to know that their work is for a worthy cause, and further encourage altruism and trust among patients.
- Staff require relevant and up-to-date information in order to be better informed themselves and to in turn provide patients with relevant and up-to-date information about how utilising their PHI policy benefits both the patient and the community.

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- Provide proof to patients or provide guarantees for waiver of any expenses up front in writing and with expert people to explain such arrangements.
  - Explanation of any likely bills that patients may receive from the hospital, and an explanation of how exactly their financial matters will be resolved if they do receive any bills – specialist and simplified billing.
  - Education programs designed for staff should have some level of flexibility in timing these programs. For night staff and staff who work non-conventional shifts, there should be programs catering for them thus increasing education program coverage.

### **Engaging with doctors**

- For clinical staff, particularly doctors, who ultimately admit patients, it is important to engage them in the process of providing not only incentives but rationale behind why PHI use is an important and positive thing to engage in. There may be times where there are positive financial incentives for doctors if the public patient, already admitted to the hospital, were to use their PHI. In such circumstances, communication by hospital staff to doctors about the patient's individual PHI membership status becomes very important.
- As per the findings indicated in previous sections, some doctors do not have problems in referring private patients to the hospital, provided that their own financial situation is not made worse by making such referrals. Indeed, in some instances, such as for VMOs with admitting rights, who see patients for

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elective surgery, consultations in their private clinics do not always refer to financial matters.

- Surgical capacity in any hospital, either private or public, is limited by a number of factors. Patients' choices aside, the number of sessions that a VMO has in a public hospital could also affect the capacity for them to refer private patients to a public hospital. The ability for the hospital admissions office to provide accurate and definitive information from the surgical list to VMOs and their secretaries would greatly help to improve the number of private patients that are referred to the public hospital. It should be noted that this is not intended to be a method to promote competition for private patients with private hospitals. Rather, it is about better communication with the doctors for allowing better information sharing regarding admission capacity.
- It is often that secretaries discuss financial matters with patients. Certainly, there are some exceptions to these arrangements, whereby the doctor would have the opportunity to discuss these matters with patients instead/too. It is important to note that establishing frequent and open channels of communication with VMOs and their secretaries should be a priority in the strategy of doctor engagement.

### **Further promotion of PHI**

- This research has identified that a lack of information about the ability to use PHI in a public hospital is often a barrier to patients choosing to use their PHI in public hospitals. Information packages should be available in all the top community languages relevant to the hospital's local community. This initiative would demonstrate that the hospital is considerate of its customer

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demographic and provides relevant information important to them in order to help them make informed decisions about financial matters.

- Reminders/alerts should be placed on all admission tools (admission forms – administrative/medical/nursing) to alert all staff to ask the patients if they would like to use their PHI for their admission at the hospital, thus making it everyone's responsibility.
- Offering incentives/rewards to departments/individuals for the most number of conversions to PHI may serve as an important motivator for staff to go the extra mile in securing more patient conversions.
- Where possible and economical to do so, offer more token free incentives (may cost some to the hospital but provided to patients for free to encourage people to use their PHI e.g. free toiletry pack, free parking etc. Such incentives provide a differentiated experience to patients who decide to use PHI for their admission.
- Face-to-face contact with patients to provide information about the advantage of PHI utilisation is an effective method in encouraging patients to use PHI. Educate patients about the use/benefits/any costs associated with the use of PHI earlier in the booking/admission process – e.g. upon booking an appointment at the start of pregnancy, at preadmission clinics etc.

### **Systems and processes relating to PHI election**

- The way in which the financial-classification election form for patients is designed may be likely to affect the way in which people answer the questions, and might even alter their answers. As mentioned previously, through the ED admission pathway, patients are required to make financial elections upon



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visiting the ED (see Appendix 6 – existing financial classification form at Canterbury Hospital, also used by Royal Prince Alfred Hospital, Concord General Repatriation Hospital and Balmain Hospital). The current election form used in NSW public hospitals ask for a lot of information, and the status of the patients' financial classification is not a question patients appreciate being asked to answer upon their arrival to the hospital during a medical emergency. However, as research has shown, in privacy-related questionnaires, the reliability of the answers tends to reduce towards the latter part of the questionnaires. That said, it may be a good idea to ask patients straight away about their financial classification, as they are more likely to provide honest answers.

- In accordance with the National Healthcare Agreement 2011, consumers have the right to elect to be treated as either public or private patients (COAG, 2011). It is therefore imperative to ensure that staff understand this concept and communicate to patients that they have a choice in their financial election, and that they don't just assume what patients would rather choose.

Also, as part of the agreement (pp. A-10) the State and Territories aim to "improve levels of informed financial consent for private patients in public and private hospitals". Informed consent relates to providing adequate and accurate information in order to patients to facilitate their choice election.

- Certainly, the National Healthcare Agreement does not encourage hospitals to direct patients towards any particular choice election or preferences; it should be understood that to be fair, any decision made by patients should be informed and assisted with adequate levels of information and consent. By default, a vast majority of patients who understand their rights of using

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Medicare as a public patient may not have an equal amount of knowledge regarding the of use their PHI as a private patient in a public hospital.

- Currently, hospitals within SLHD employ PHI fund eligibility checking in place; however, it is a manual and labour-intensive process, and it depends on consumers actually declaring their PHI status. In terms of negotiation with health funds and changes in IT systems, there could be potential to improve this eligibility checking system; ideally, if the mechanism could be integrated with hospital-based clinical information systems (which currently captures the patient's Medicare card number) to also automatically check for the patients' PHI status, then the whole process of PHI election would be made much easier.

## **10.2. Directions For The Future**

In order to assess the feasibility of the recommendations and how the findings could be applied in a practical sense within hospitals in SLHD, there is a need to discuss with the key executives and staff about these findings and recommendations. This focus group was conducted in May 2013 at SLHD which consisted of revenue managers, general managers and various health district executives. At the beginning of the focus group, a list of the key findings in the thesis were presented, a range of recommendations that could be applied at hospital level were discussed. The recommendations were to assist with increasing the public patient's conversion to PHI in these health facilities. One of the primary aims of the focus group is for the participants to comment on what they may see as the barriers or limitations to these recommendations, with another key aim being for participants to provide their views on whether they see any other ways that could be leveraged in addition to the recommendations put forward.

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Some of the themes that were evident in the discussion among participants at the focus group have revolved around the following questions. The transcript of this focus group session was then typed up, and a qualitative thematic analysis was undertaken. An external reviewer also conducted the same qualitative thematic analysis on these questions and answers. The goal of conducting the same analysis again was to confirm that the qualitative analysis and interpretation of the themes mentioned by focus group participants were not misrepresented. Results of the two qualitative thematic analyses had a matching rate of approximately 90% indicating a high level of reliability. The list of questions and answers are grouped into themes below:

### **Why do some people decide to go to public hospital and use PHI?**

Regarding this question, some participants of the focus group suggested that, “A lot of people who use PHI do so because they would like to help out the local hospital”. It has also been mentioned that, “Patients can ask to be admitted as a private patient under the care of a specific doctor in a public hospital”.

However, the participants have also said that “There is a cohort of patients who consider the benefit to themselves, personally, of using PHI as being something that is very important.”

There is some agreement from the participants that for hospitals, there is still the “Need to understand what makes people choose to go to a public hospital”.

### **Why do some people decide to go to private hospital?**

The focus group ventured into a set of discussions involving around some people decide to go to private hospital, in order to assist with understanding the alternative options of people going to the public hospital.

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Some participants believe that “A specific group of people go to a private hospital” and that there is the “Need to understand what makes people choose to go to a private hospital”. These comments meant that in their opinion, there are certain motivations behind why some people would choose to go to a private hospital as opposed to why some people would choose to go to a public hospital.

As a way to understand this, it has been suggested that the participants needed to understand “the differentiator that makes people want to go to private hospital vs public hospital”.

In addition to some of the reasons discussed by the participants regarding reasons as to why people would choose to go to a private hospital, some people have said that certain individuals choose to go private “because it has a sense of status and prestige”.

There are also practical reasons given by some participants that “If a patient can be seen quicker in a private hospital then they would want to be seen quicker so they will go to the private hospital.” Or “If a private hospital could offer a more certain date of surgery than a public hospital, then patient is more likely to go to a private hospital”.

**What are some of the issues with staff involvement in patient’s decision on whether or not to use PHI?**

A mixed range of responses were provided for this question; they are listed as follows:

- An admitted patient, staff member cannot give her invoice
- Staff members were very surprised that the patient wanted to use their PHI

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- Staff member did not encourage the patient to use their PHI
  - Staff member provided incorrect information to the patient
  - Staff member showed little interest in helping the patient to reduce their fear of uncertainty
  - Some nursing staff was really supportive of the patient using PHI

A few participants in the focus group have mentioned that they have noted that some patients have said that, “I have PHI, was put in a private room without anyone asking me about private health insurance so I was really in as a public patient”. It can be seen that participants in the focus group were quite concerned about the level of staff engagement with patients regarding PHI related matters. It was not specific as to which professional staff group the participants were focusing on.

### **Additional ways to help patients with the decision of using PHI**

In relation to additional ways to help patients with decision of using PHI, some of the participants have said that there is a stronger need to “educate administrative staff about PHI information, then being able to provide information to the patient” as well as to educate administrative staff that the patients have a right to choose whether to use their PHI or their Medicare card”. Emphasis from these comments appears to focus on education and that the participants think there is a lack of education or amount of information given to administrative staff.

Furthermore, participants commented that “the strategies to engage elderly and younger patients for PHI utilisation may be different” and that “Hospitals with specialities or prestige can make use of these, make patients feel special when using their PHI, for example, RPA women and babies”. Here, it is possible to see

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that practical solutions are being suggested by the focus group participants, for example, for staff to differentiate or tailor their approaches when engaging with different patients, as well as differentiating the hospital experience or providing a particular varied image or experience to patients for them to see the reason to use their PHI.

Next, the participants have also commend that “there is advantage to still waiving the patient's OOP expenses, as a good will and patients would likely to use it again when they are admitted” although this may seem like an arbitrary comment, it is actually quite practical as it has been proven in the thesis that by reducing financial risk for patients, it improves the likelihood of patients choosing to use their PHI.

It is also noted from the participants that the “thesis recommendations point to many things that hospitals have also thought to do or are implementing”; these comments are reassuring, as it shows that the recommendations and strategies recommended by this thesis are relatively practical and are being accepted by the wider group of hospital managers.

### **Barriers to patients choosing to use PHI in public hospitals**

When the discussion moved towards the points covering barriers to patients choosing to use PHI in public hospitals, it was noted from these comments that “people don't know they can use PHI for public hospital admission” and “People have limited knowledge about PHI utilisation and are not aware of the benefits, for example, that gap may be waived”. However, it has been further commented on by some focus group participants, “It is complex when the OOP expenses for accommodation charge is waived, but when specialist doctors still charge a gap fee above the Medicare schedule fee”. This highlights the problem that this thesis also discusses extensively, resonating similar considerations in previous sections.

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Moreover, further comments were made by the participants, such as, “PHI funds are less likely to encourage people to use their private health insurance if possible, and in fact they discourage it” which highlighted the barriers that PHI funds put in place to prevent reductions in their profitability.

### **Promotion to patients about using PHI in public hospitals**

When the focus group discussion progressed further into the topic of promotion to patients on using PHI in public hospitals, participants mentioned that “there may be particular healthcare pathways or services that health funds want to associate themselves with a public hospital”. This is an innovative model on how public hospitals could try to engage with the PHI funds, and the proposed strategy focuses on delivering value to the health funds and their members as well as providing some concrete rationale to insured patients at public hospitals as to why they should be using their PHI.

Next, some staff have rightly pointed out that “We are not great at marketing what we do (the great health care services we provide) because that hasn’t been our world”, and that “There is great value in what we provide in the public health system and that the private health system can’t replace. They both have a place within the whole system.” However, the emphasis, traditionally, has mainly been that the public health system is in place only for public patients’ use, and it is about time that such assumptions changed and became more balanced, that is, to incorporate both private and public election choices in a public hospital.

There is a strong consensus among the focus group participants that there is the “Need to improve promotion of private health insurance and what it does for the local hospital”, and that the hospital facilities “Need to work on the incentives to patients more”. These comments reflect the group’s concern that there is probably an

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inadequate level of promotion of benefits, and that the benefits themselves may not be enough to attract patients to convert.

The group then goes on to provide a list of possible strategies in improving promotion of PHI utilisation benefits in public hospitals. These comments include: “Promote the use of PHI in public hospitals through local media or social media to increase people's awareness of PHI utilisation and personal benefits they may bring.” Plus the comment that “promoting benefits in isolation is not effective, but promoting the benefits as a package is more of an attractor” shows that the participants have felt that to change the public's view of PHI in public hospitals, there needs to be more effort made to expand current promotional communication, and in particular to package up the benefits of using PHI with a new brand image.

### **What is in it for private health funds for patients to use PHI in a public hospital?**

One of the participant comments that shed some relevance to this study is that “It costs less for the health fund if a patient is treated in a public hospital rather than a private hospital”. King (2013) in his report alluded that PHI funds generally take a dim view on public hospitals encouraging insured patients who come in as a public patient to use their PHI policy, as it reduces their profitability. This is because if a patient comes into the hospital and elect to be a public patient even though they may hold PHI cover, PHI funds do not have to pay for the claim, hence if they use their PHI for their public hospital admissions then the PHI fund's profitability is reduced due to increased cost. However there are advantages for these funds when patients can be treated at a lower cost. Furthermore, PHI funds usually set up “member-choice” hospitals (usually private hospitals) where patients can use their PHI, so with reduced accommodation charges or waiver of gap payment, public hospital could also play a bigger role in assisting in offering more choices to patients.



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In summarising the recommendations from the above sections, it should be noted that a range of factors, including PHI conversion methods, patient perceptions, the PHI benefit offering, and staff and patient knowledge about PHI, have immense power in influencing patients' decisions about whether or not to use their PHI for a public hospital admission.

For example, it has been found that with the introduction of EPI financial classification and the endorsement of the classification by all doctors at Canterbury Hospital, patients entering the hospitals via the ED encounter very few barriers that come between them and choosing to become a private patient. When patients feel that they are not exposed to any financial risks or unknown factors, their anxiety about changing financial election reduces. Notably, one of the major findings from the questionnaire was that lack of knowledge that PHI can be used in a public hospital is what primarily prevents people from using their PHI in public hospitals, followed by the myth that insurance premiums may go up if they use their PHI.

Earlier sections had also discussed recommendations stating that the introduction of extensive training for frontline ED clerical staff on how to target patients' lack of knowledge of PHI, as well as how to answer PHI-related enquiries would be worthwhile. This type of training should be aimed at developing a consistent approach or a standardised set of answers on PHI to provide cognitive assurance to patients that these answers are legitimate and trustworthy. Further to this, the visual communication and promotion of PHI utilisation inside the hospital should be further enhanced. For example, brightly coloured posters in prominent locations around the hospital and patient care areas is a must; these materials should be also displayed to appeal to patient relatives, staff and visitors. There is a limited number of promotional locations and options available in public hospitals, so the options will

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need to be further explored and expanded. Some locations could include hospital lifts, patient waiting areas, telephone hold messages, etc. These strategies focus on making PHI issues a topic that has a shared meaning for both staff and hospital patients. Public health service providers should communicate the purpose of encouraging PHI utilisation openly, and thus by making information about PHI more accessible to patients, it provides more opportunities for patients to make better and more informed financial decisions.

In particular, to reinforce and strengthen the understanding of PHI utilisation knowledge among the public, some active education of frontline staff is required. This, in addition to the aforementioned standardised training for scripts and information for administrative staff, this training should be expanded to include education of clinical professionals such as doctors, nurses and other allied health clinical professionals. This training should focus on the reasons for PHI capture, PHI utilisation and their implications for public hospitals. Such training can focus on what clinical professionals need to understand about what to communicate to patients and how to deliver such messages. Particularly, their knowledge of PHI utilisation in public hospitals and endorsement can serve as an important way to provide a sense of assurance to patients and their families. Clinical professionals' endorsement, coupled with administrative staff's detailed explanation and assistance in election, can make PHI utilisation much easier for patients.

Secondly, since currently, there is no available data or IT system that the hospital can utilise to detect whether or not a patient holds PHI, the hospital should utilise every patient contact opportunity as a way to detect whether a patient has PHI. Sometimes, patients could be transferred from or discharged to a private hospital; this occasionally means that the patient holds PHI. Such information is usually

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recorded on the patient administration system. Additionally, the hospital patient administration system also captures information about the patient's next of kin, and anecdotally, it has been found that if the next of kin or relatives have PHI, there is the likelihood that the patient also has PHI. If there are barriers that prevent the patients from declaring their PHI membership, then some leading questions could be asked by the administrative staff about their next of kins' PHI status, which may prompt the patient to declaring their own PHI membership if they did indeed hold PHI.

Administrative staff should aim to use these opportunities to obtain PHI information about patients wherever possible.

Furthermore, the project through its findings has concluded that for the particular case at Canterbury Hospital, there is substantial potential to increase PHI utilisation in the elective surgery corridor, wherein patients who present to the public hospital may also hold PHI but have never used it in a public hospital. Active liaison with doctors' secretaries seems to have helped to improve the overall PHI capture rate at Canterbury Hospital. In addition to this, there are several factors that have influenced why such a strategy had been effective in improving PHI capture and conversion rate. These include: specialist doctors agreeing not to charge patients a gap fee for elective procedures at Canterbury Hospital; Canterbury Hospital agreeing not to charge the patient a PHI excess, providing convenience and peace of mind for patients electing to be private; a good working relationship between the hospital staff, including admitting doctors and doctors' secretaries, in actively communicating about patients' PHI status. The above findings have indicated that these strategies are effective in increasing the amount of patients electing to be private, and such strategies could also be employed by other public hospitals to improve their PHI capture and conversion rate.

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Furthermore, there is a range of strategies that should be implemented to increase the contact opportunities of revenue staff and patients who potentially hold PHI. At Canterbury Hospital, this has been achieved through interviewing every newly admitted patient regardless of how they have entered the hospital (either via elective corridor, ED corridor or transfers). Of course, it is possible that some patients who came via these various corridors may have already been converted to being private patients – these patients are not the focus of these additional efforts. Instead, particular efforts should be focused on patients who have not yet declared their PHI status. Also, the patient registration system used by hospitals records patients' previous admission information; patients who have used PHI in previous hospital admissions but have not declared or used their PHI the current admission should be interviewed more extensively.

### **Policy changes to the PHI rebate**

In March 2012, the Australian Federal Government passed a bill to introduce the income means-test to assess people's eligibility for the 30% rebate for PHI insurance. Under this new policy, some individuals or families with an income higher than a certain threshold could miss out on the insurance premium rebate. Many scholars feared that this could affect the number of people who would still be willing to remain in a PHI scheme. Others were more optimistic and argued that although the introduction of a means-tested system appeared to deter people and could result in high drop-out rates from PHI (given the introduction of the MLS – an additional tax on top of the 1.5% Medicare levy payable for most taxpayers – which is levied to Australian taxpayers who earn above the MLS thresholds and don't have private hospital cover), it may not be wise for some taxpayers to opt-out of PHI, as it may end up costing them even more. In other words, although the eligibility for PHI rebate

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is going to be means tested for income, an increase of the MLS for people not holding PHI would represent financial penalties. Some other scholars have therefore argued that the means test for qualifying PHI rebate is not likely to result in lots of people dropping out of their PHI cover (Savage, 2012).

On the other hand, some less optimistic commentators have argued that there will be a marked reduction in PHI membership, as the means test is going to discourage people from continuing their membership (Foster & Cornish, 2012). Even though at times, this may not seem logical from a financial perspective (for example, even if in certain circumstances the cost of extra levy does not offset the cost of insurance premiums), people may even perceive the additional tax levy as a punishment, and as a show of resentment may therefore decide to opt out of their PHI. This may be seen as another example of the lack of rationality in human decision-making, as a lack of objective consideration of the potential financial losses and gains would be involved in this sort of decision. Notwithstanding this, some individuals would actually take the time to rationally compare their options through various models and analyses and weigh up their financial losses and gains under the new policy, and decide whether or not it is worthwhile for them to still be insured privately.

The effect of this new policy is not within the scope of this thesis. However, should there be any marked reduction in PHI membership in Australia, it is likely that this may affect the number of people with PHI attending public hospitals, as the population pool would be reduced, assuming everything else is equal. This could therefore also have an effect on the number of people who want to use their PHI in public hospitals. However, the recent PHI membership data (usually released on a quarterly basis) from PHIAC shows that PHI membership across the nation has

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either remained relatively static or grown slowly, with similar trends having also been observed in the state of NSW (PHIAC, 2012b).

### **Reaction of private health insurance funds**

Some scholars have argued that the increase in public hospitals' effort in collecting PHI patient fees will adversely affect the PHI industry and thereby cause an increase in the health fund's cost base, resulting in an adverse selection process for the holders of PHI. The consequence of that could be that there would be a reduction in the amount of the population willing to continue with their PHI membership (Buchmueller, 2008).

However, there are also various other views expressed by other scholars regarding the claims by the PHI funds. Some scholars have argued that the coordinated approach by the government in increasing financial penalties for people not holding PHI and the various incentives to encourage people to remain covered by PHI will stop people from exiting their health funds (Shamsullah, 2011). If anything, these measures could possibly mean that more and more people would be more likely to become insured under PHI in the long run if they have not yet joined a PHI fund, as these incentives and penalties exert forces that shape the behaviour of the population and make the population increase its PHI coverage.

Based on the facts identified in earlier sections by reviewing the trend of PHI membership published by PHIAC (PHIAC, 2012b), it appears that across Australia, the amount of people holding PHI with hospital cover has remained relatively steady within the last 5 years, with slight increases experienced most recently due to changes to government rebate and incentives. Depending on the individual's own circumstances, people would decide whether or not to purchase PHI or whether or

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not to remain covered by PHI. However, statistical facts have indicated that there has not been any reduction in PHI membership experienced in NSW or across the nation. Future policy changes may or may not significantly affect the membership of PHI, however, any recommendations and implications of this study that relate to future projections should also be made with the latest PHI-related policy developments in mind, because these could affect the way consumers behave.

### **Activity-based funding and PHI revenue**

Activity-based funding (ABF) commenced in the NSW public health system from 1 July 2012. Under this regime, the public hospitals are funded under an efficient price cost per episode of care arrangement. The Ministry of Health agrees on the number of activity units that they will purchase from each of the LHDs, at a specific, agreed price. The goal is to encourage public hospitals to improve their operation efficiency and reduce wastage.

At the time of writing, PHI revenue is still considered to be an important revenue component under the funding model. Seeing as though the efficiency-based model considers PHI revenue as a given under ABF, it is determined that PHI revenue activities would attract a lower funding price due to its own revenue stream. Based on this, one could argue that public patient activities attract higher funding dollars than the same activity would if performed on private patients. If this argument is true, then there could be a possible disincentive to convert private patients, as treating public patients attracts more funding. This chapter only briefly mentions about ABF and PHI revenue because ABF does not specifically affect the private accommodation revenue of a public hospital, if a question needs to be raised about relationship between PHI revenue for public hospitals and ABF, a different research thesis is needed altogether. However, currently as revenue targets set for public

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hospitals are unlikely to disappear, the relationship between PHI revenue and ABF still need to be further explored. In addition to this, as there are some aspects of the ABF arrangement that are still not yet clear, an future independent research theme in its own right could be to explore how the PHI revenue could be affected by the ABF model.

It is noted that some may argue that by pointing out using PHI actually helps the public healthcare system is a mere attempt to find a scapegoat for the lack of government funding provided to the health service. However, as touched on earlier, it is an undeniable fact that the expenditure of health services is increasing in all OECD countries, and that the ageing population and expectation from the public requires healthcare service providers to increase their expenditure even further (Hurst, 2000). The nature of the healthcare service in Australia means that the limited amount of taxpayers' money available can only provide a finite level or prevalence of healthcare service. It is true that in a user-paid healthcare system like that of the US, people may not be encouraged to use their PHI; this is because the healthcare funding model there is vastly different, and US health expenditure is not limited quite so vastly by lack of government funding. The reality in the Australian context is that it is difficult to ignore the role that PHI funds play in the health funding landscape. A private and public funding partnership may seem a sensible way to make the health service provision in Australia sustainable and affordable.



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## 11. Conclusion

In this research, the rationale behind why patients choose to use or not to use PHI in public hospitals is surveyed. The results of 336 out of 450 respondents (indicating a 74.67% response rate) identified several main reasons as to why patients chose to use their PHI for the public hospital admission: the possibility of admission to a single room; the ability to choose their own preferred doctor; the opportunity to help the hospital and the community; and the occasion to avail of some of the other benefits that come with using PHI. The results have also identified several main reasons as to why patients have not chosen to use their PHI: they did not know they could use their PHI for their public hospital stay; they were worried that their health insurance premiums would increase if they used their PHI; and fear of out-of-pocket expenses. In the second part of this research thesis, a financial model was developed to aid the analysis of the cost and revenue impact of encouraging patients to use PHI. It has been found that during the 2011/12 financial year at Canterbury Hospital, a revenue of approximately \$3 million (AUD) was raised, with a cost of \$519,176.14. The return on investment (ROI) was 5.59 (i.e. the net revenue was 5.59 times that of the cost or 559%), indicating an excellent return versus cost. These results reaffirm that the efforts that public hospitals have devoted to encouraging patients to use PHI is worthwhile.

The findings from this thesis shed some light on strategies that could potentially be used to develop possible methods for how PHI capture and conversion rate could be improved in other NSW public hospitals. Some scholars have argued that public hospitals should not actively encourage patients to use their PHI, as it is a form of cost shifting. However, looking at the reality of the multiple pressures bearing down on the Australian healthcare system and assessing pitfalls of a mainly government-

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funded universal healthcare system, alternative ways of supporting the public health system funding is needed. Indeed, enabling patients to have a choice by allowing PHI to play a more active role in supporting a system under pressure may help to increase the longevity and sustainability of the nation's public healthcare system.

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## 13. Appendices

### Appendix 1: SLHD site-specific approval

ADDRESS FOR ALL CORRESPONDENCE  
RESEARCH DEVELOPMENT OFFICE  
ROYAL PRINCE ALFRED HOSPITAL  
CAMPERDOWN NSW 2050

TELEPHONE: (02) 9515 6766  
FACSIMILE: (02) 9515 7176  
EMAIL: [lesley.townsend@email.cs.nsw.gov.au](mailto:lesley.townsend@email.cs.nsw.gov.au)  
REFERENCE: X11-0185



Health  
Sydney  
Local Health District

9 September 2011

Mr J Cheng  
Director, Corporate Services  
Canterbury Hospital  
Thorncraft Parade  
CAMPSIE NSW 2194

Dear Mr Cheng,

**Re: Protocol No X11-0185 - "Decision to use Private Health Insurance in a Public Hospital, Its Impact and Future Directions"**

**HREC/11/RPAH/269**

**LNRSSA/11/RPAH/451**

Thank you for submitting a Site Specific Assessment Form for this study. I am pleased to inform you that authorisation has been granted for it to be undertaken at the Canterbury Hospital.

The approved information and consent documents for use at this site are:

- Information for Participants (Canterbury Version 1.1, 20 August 2011)
- Patient Survey on Private Health Insurance (Canterbury Version 1.1, 20 August 2011)

The following conditions apply to this research study. These are additional to those conditions imposed by the human research ethics committee (HREC) that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research, which may affect the ethical acceptability of the study and which are submitted to the lead HREC for review, must be copied to me.

General Correspondence  
PO Box M30  
Missenden Road, NSW, 2050  
Email: [slhdn.esu@sswahs.nsw.gov.au](mailto:slhdn.esu@sswahs.nsw.gov.au)  
Website: [www.health.nsw.gov.au/sydhnl/](http://www.health.nsw.gov.au/sydhnl/)

Sydney Local Health District  
ABN 17 520 269 052  
Level 11 North, King George V Building  
83 Missenden Rd  
CAMPERDOWN, NSW, 2050  
Tel 612 9515 8600 Fax 612 9515 9610



## Appendix 2: SLHD ethics approval

ADDRESS FOR ALL CORRESPONDENCE  
RESEARCH DEVELOPMENT OFFICE  
ROYAL PRINCE ALFRED HOSPITAL  
CAMPERDOWN NSW 2050



Health  
Sydney  
Local Health District

TELEPHONE: (02) 9515 6766  
FACSIMILE: (02) 9515 7176  
EMAIL: [lesley.townsend@email.cs.nsw.gov.au](mailto:lesley.townsend@email.cs.nsw.gov.au)  
REFERENCE: X11-0185 & HREC/11/RPAH/269

15 August 2011

Mr J Cheng  
Director, Corporate Services  
Canterbury Hospital  
Thorncraft Parade  
CAMPSIE NSW 2194

Dear Mr Cheng,

**Re: Protocol No X11-0185 & HREC/11/RPAH/269 - "Decision to use Private Health Insurance in a Public Hospital, Its Impact and Future Directions"**

Thank you for submitting the above negligible risk research proposal, which was considered by the Executive of the Ethics Review Committee, at its meeting of 28 July 2011. Ethics approval is granted.

The proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research*.

This approval includes the following:

- Information for Participants (Master Version 1.1, 20 July 2011)
- Patient Survey on Private Health Insurance (Master Version 1.1, 20 July 2011)

You are asked to note the following:

- **This letter constitutes ethical approval only. You must NOT commence this research project at ANY site until you have submitted a Site Specific Assessment Form to the Research Governance Officer and received separate authorisation from the Chief Executive or delegate of that site.**

General Correspondence  
PO Box M30  
Missenden Road, NSW, 2050  
Email: [slhd.esu@sswhs.nsw.gov.au](mailto:slhd.esu@sswhs.nsw.gov.au)  
Website: [www.health.nsw.gov.au/sydlhd/](http://www.health.nsw.gov.au/sydlhd/)

Sydney Local Health District  
ABN 17 520 269 052  
Level 11 North, King George V Building  
83 Missenden Rd  
CAMPERDOWN, NSW, 2050  
Tel 612 9515 9600 Fax 612 9515 9610

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**On the basis of this ethics approval, authorisation may be sought to conduct this study within any NSW public health organisation and/or within any private organisation which has entered into an appropriate memorandum of understanding with the Sydney Local Health District or the Sydney South West Area Health Service.**

The Executive noted that authorisation will be sought to conduct the study at the following sites:

- Canterbury Hospital
- Bankstown Hospital
- This approval is valid for four years, and the Committee requires that you furnish it with annual reports on the study's progress beginning in August 2012.
- This human research ethics committee (HREC) has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review and is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.
- You must immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.
- You must notify the HREC of proposed changes to the research protocol or conduct of the research in the specified format.
- You must notify the HREC and other participating sites, giving reasons, if the project is discontinued at a site before the expected date of completion.
- Where appropriate, the Committee recommends that you consult with your Medical Defence Union to ensure that you are adequately covered for the purposes of conducting this study.

Should you have any queries about the Committee's consideration of your project, please contact me. The Committee's Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Sydney Local Health District website.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

---

The Ethics Review Committee wishes you every success in your research.

Yours sincerely,

A handwritten signature in cursive script that reads "Lesley Townsend".

Lesley Townsend  
**Executive Officer**  
**Ethics Review Committee (RPAH Zone)**

HERC\LNR.APP\11-08

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## Appendix 3: Research questionnaire



### ***Research Study: Decision To Use Private Health Insurance In A Public Hospital, Its Impact And Future Directions***

#### **INFORMATION FOR PARTICIPANTS**

##### **Introduction**

You are invited to take part in a research study into patients' decision to use or not to use private health insurance in a public hospital.

The study is being conducted within this institution by Jason Cheng, principal researcher, Sydney Local Health District as part of the requirements for a doctorate of business administration degree under the supervision of Dr Paul Theivananthampillai, University of Tasmania and A/Prof Jeff Patrick, Sydney Local Health District.

##### **Study Procedures**

If you agree to participate, you are asked to complete the attached survey and a hospital staff will collect it from you. The survey seeks information on whether or not you chose to use private health insurance during your hospital admission. It will take about 5 minutes to do.

##### **Benefits**

While we intend that this research study will further health service knowledge, it will not be of direct benefit to you.

##### **Costs**

Participation in this study will not cost you anything, nor will you be paid.

##### **Voluntary Participation**

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason.

##### **Confidentiality**

All the information collected from you for the study will be treated confidentially, and only the researchers named above will have access to it. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

##### **Further Information**

If you would like to know more about this study at any stage, please feel free to contact Jason on 9787 0232.

---

This information sheet is for you to keep.

**Ethics Approval and Complaints**

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney Local Health District. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X11-0185.



<b>Patient survey on private health insurance</b>	<b>CANTERBURY HOSPITAL</b>
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Please take a moment to help us understand why some patients chose to use private health insurance and some would not. When you have finished, a staff member will come and collect it from you.

***Private health insurance and you***

<p><b>1.</b> Have you been asked by a staff member if you hold private health insurance during this admission to the hospital?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p><b>2.</b> Do you hold a current private health insurance policy with hospital cover?</p> <p><input type="checkbox"/> Yes <b>[Please go to question 4]</b></p> <p><input type="checkbox"/> No <b>[Please go to question 3]</b></p>
<p><b>3.</b> Do you intend to purchase private health insurance in the next 12 months?</p> <p><input type="checkbox"/> Yes</p> <p><b>[Thank you for completing this survey]</b></p> <p><input type="checkbox"/> No</p> <p><b>[Thank you for completing this survey]</b></p>	<p><b>4.</b> Did you use your private health insurance for your admission this time to Canterbury Hospital?</p> <p><input type="checkbox"/> Yes <b>[Please go to question 5]</b></p> <p><input type="checkbox"/> No <b>[Please go to question 6]</b></p>
<p><b>5.</b> Why did you use your private health insurance for your admission this time to the hospital? (Please tick as many answers that apply)</p> <p><input type="checkbox"/> Choice of my own doctor</p> <p><input type="checkbox"/> Possibility to be admitted to a single room</p> <p><input type="checkbox"/> Was told won't cost me anything so just signed up</p> <p><input type="checkbox"/> Free TV hire</p> <p><input type="checkbox"/> Free parking</p> <p><input type="checkbox"/> Free newspaper</p> <p><input type="checkbox"/> Free toiletry pack</p> <p><input type="checkbox"/> Waived my excess</p> <p><input type="checkbox"/> Help the hospital and the community</p> <p><input type="checkbox"/> Other reasons, please specify</p> <p>_____</p> <p>_____</p>	<p><b>6.</b> Why did you choose NOT to use your private health insurance? (Please tick as many answers that apply)</p> <p><input type="checkbox"/> I didn't want to pay an excess</p> <p><input type="checkbox"/> I didn't think about using it</p> <p><input type="checkbox"/> I'm worried about the doctor's fees (gap charges)</p> <p><input type="checkbox"/> I'm worried that my insurance premium may go up if I claim</p> <p><input type="checkbox"/> I didn't think private health insurance covered my public hospital stay</p> <p><input type="checkbox"/> I was not asked about using it</p> <p><input type="checkbox"/> A hospital staff told me not to use it</p> <p><input type="checkbox"/> Someone else told me not to use it</p> <p><input type="checkbox"/> Other reasons, please specify</p> <p>_____</p> <p>_____</p>

<p><b>7. Why did you purchase private health insurance? (Please tick as many answers that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> For my admission to a private hospital</li> <li><input type="checkbox"/> For tax purposes</li> <li><input type="checkbox"/> Always had it</li> <li><input type="checkbox"/> Parents had it</li> <li><input type="checkbox"/> Just in case that I ever need it</li> <li><input type="checkbox"/> For peace of mind</li> <li><input type="checkbox"/> Family circumstances changed</li> <li><input type="checkbox"/> Enable quicker access to care</li> <li><input type="checkbox"/> Other reasons, please specify</li> </ul> <p>_____</p>	<p><b>8. Do you think using private health insurance will make your insurance premium go up?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, because I used it</li> <li><input type="checkbox"/> No that's not the reason, because it will go up anyway each year even if I don't use it</li> <li><input type="checkbox"/> No, it will not change the amount of premium that I pay</li> <li><input type="checkbox"/> Not sure</li> </ul>
---	---

***Knowledge about private health insurance***

<p><b>9. I understand my health insurance cover (inclusions, exclusions, excesses, premium etc.) very well.</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Strongly agree</li> <li><input type="checkbox"/> Agree</li> <li><input type="checkbox"/> Neutral</li> <li><input type="checkbox"/> Disagree</li> <li><input type="checkbox"/> Strongly disagree</li> </ul>	<p><b>10. Who approached you or mentioned to you about using Private Health Insurance? (Please tick as many answers that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Emergency department clerical staff</li> <li><input type="checkbox"/> Admissions/enquiries staff</li> <li><input type="checkbox"/> Waitlist staff</li> <li><input type="checkbox"/> Ward staff</li> <li><input type="checkbox"/> My specialist doctor</li> <li><input type="checkbox"/> Family members/friends</li> <li><input type="checkbox"/> Other, please specify</li> </ul> <p>_____</p> <p>_____</p>
<p><b>11. Was the staff member who informed you about choice of financial election knowledgeable about private health insurance?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Strongly agree</li> <li><input type="checkbox"/> Agree</li> <li><input type="checkbox"/> Neutral</li> <li><input type="checkbox"/> Disagree</li> <li><input type="checkbox"/> Strongly disagree</li> </ul>	<p><b>13. If you have private health insurance (with hospital cover) what would make you want to use your private health insurance next time if you are admitted to a public hospital? (Please tick as many answers that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Choice of my own doctor</li> <li><input type="checkbox"/> Possibility to be admitted to a single room</li> <li><input type="checkbox"/> Was told won't cost me anything so would just sign up for it</li> <li><input type="checkbox"/> Free TV hire</li> <li><input type="checkbox"/> Free parking</li> <li><input type="checkbox"/> Free newspaper</li> <li><input type="checkbox"/> Free toiletry pack</li> <li><input type="checkbox"/> Waiving my excess</li> <li><input type="checkbox"/> Help the hospital and the community</li> <li><input type="checkbox"/> Other reasons, please specify</li> </ul>
<p><b>12. I have noticed information about using Private Health Insurance at Canterbury Hospital through the following communication medium: (Please tick as many as may apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Telephone on hold message</li> <li><input type="checkbox"/> Hospital patients guide</li> <li><input type="checkbox"/> Hospital posters</li> <li><input type="checkbox"/> Hospital brochures</li> <li><input type="checkbox"/> Other, please specify</li> </ul> <p>_____</p> <p>_____</p>	



---

	<input type="checkbox"/> _____ _____
--	---

***Additional comments relating to this survey on private health insurance***

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---

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**About you (optional)**

**Sex** \_\_\_\_\_ **E-mail** \_\_\_\_\_ **Age** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Suburb, state, postcode** \_\_\_\_\_

**Would you like to participate further studies if required?** ☐ Yes ☐ No

***Your comments are valuable. Thank you for your participation!***

## Appendix 4: Canterbury Hospital EPI patient letter from hospital general manager



Dear Emergency Department patient

Thank you very much for using your private health insurance. Patients' use of their health insurance has a significant impact on Canterbury Hospital and helps the hospital provide its high quality care.

You are being admitted into Canterbury Hospital as an Emergency Privately Insured patient ("EPI"). This means that you will not have any out of pocket expenses for this admission. This includes all costs associated with accommodation, pathology, radiology or any medical procedures.

As an EPI patient, you are being admitted into a team-orientated environment under the leadership of the nominated admitting doctor. This team will be providing care for you whilst in the hospital.

Our "Simplified Billing" system ensures that all bills, other than from your doctor or anaesthetist, will be processed automatically through Medicare and your health fund for you. Any bill you may receive from your doctor or anaesthetist for this admission will be fully covered by Medicare and your health fund.

Thank you for choosing to be admitted as an EPI patient. If you have any questions please contact the Private Patient Officer on 9787 0961.

Gary Miller  
General Manager



## Appendix 5: Canterbury Hospital private patient thank you letter from hospital general manager

Canterbury Hospital

SYDNEY SOUTH WEST  
AREA HEALTH SERVICE  
NSW HEALTH

Contact Reference: [REDACTED]

[REDACTED]  
Ms [REDACTED]  
[REDACTED] Street  
BELMORE  
NSW 2192

Dear Ms [REDACTED]

RE: [REDACTED]

On behalf of management and staff, I would like to thank you for choosing to use your private health insurance cover while receiving care at Canterbury Hospital.

The use of private health insurance allows the hospital to recover costs of hospital accommodation from health funds. It also reduces many other costs associated with the care of our patients.

The revenue generated from the use of private health insurance enables the hospital to maintain and improve existing services as well as develop new initiatives for the community.

If you have specific questions about the use of your health insurance, please call the Private Patient Officer on:

Telephone: 02 9787 0278

Fax: 02 9787 0126

Email: [Canterbury@email.cs.nsw.gov.au](mailto:Canterbury@email.cs.nsw.gov.au)

If you have any comments or feedback, please call the Patient Liaison Officer on:

Telephone: 02 9787 0151

Thank you again for making a real contribution to Canterbury Hospital.

Yours sincerely

[REDACTED]  
General Manager

Canterbury Hospital  
A facility of SSWAHS  
Canterbury Road, Campsie NSW 2194  
Tel 61 2 9787 0000 Fax 61 2 9787 0031



## Appendix 6: SLHD inpatient election form

<b>Health</b> Sydney Local Health District <b>Inpatient Election Form</b> For Medicare Eligible Patients. (Overseas residents, Department of Veterans' Affairs, Compensable Patients to complete separate forms)	Hospital: MRN: Surname: Given Names: DOB: Sex:	RPAH IRO CRGH Canterbury Balmain
	Medicare Number: _____ / _____ Expiry Date: ____/____/____ Health Fund Name: _____ Membership Number: _____ Hospital Accommodation Rates Shared Ward: \$ _____ Single Room: \$ _____ Day Only: \$ _____	
<p><i>Please ensure that you have read and understood the Inpatient Election Information Sheet prior to completing the Inpatient Election Form. Hospital staff are available to answer any questions you may have concerning the Inpatient Election Form and the Inpatient Election Information Sheet.</i></p> <p>The personal information provided in this form will be treated in accordance with privacy law. Please refer to Department of Health Privacy Policy for further details. This election form is to be completed and signed by the patient or by a legally authorised representative on behalf of the patient (eg parent).</p>		
<b>Private (Chargeable) Patient Election</b>		
<input type="checkbox"/> I elect to be admitted as a private patient treated by Dr _____ I understand that I am responsible for the payment of hospital accommodation charges, medical service fees (clinical and diagnostic) and if applicable other services such as surgically implanted prosthesis relating to my admission, which are not covered by Medicare or my health fund. I further understand that if my health insurance cover includes an excess, I am responsible for this amount. I understand that if I do not have private health insurance, I am responsible for all costs, which are not covered by Medicare. Health Insurance Excess <input type="checkbox"/> Yes <input type="checkbox"/> No Excess Amount \$ _____ Other comments concerning health fund coverage: _____ <input type="checkbox"/> I request to be accommodated in a single room subject to availability. I understand that I will be charged at a higher accommodation rate per day for occupancy of a single room and that I am responsible for the payment of any fees not covered by my health fund. <i>Please note that single rooms may be allocated to other patients based on clinical needs. If a patient's condition warrants a single room you may be required to move from your single room to assist with this clinical need.</i> Patient Signature: _____ Date: ____/____/____		
<b>Hospital (Non-Chargeable) Patient Election</b>		
<input type="checkbox"/> I elect to be admitted as a public patient. I understand that I will be treated by a doctor(s) nominated by the hospital and will not be charged for hospital accommodation, medical services (clinical and diagnostic) and if applicable other services such as surgically implanted prostheses. Patient Signature: _____ Date: ____/____/____		
<b>Patient Declaration</b>		
<input type="checkbox"/> I have received the Inpatient Election Information Sheet, which provides information on my election decision. I have read and understood this Election form and the Inpatient Election Information Sheet, which explains how my election decision will affect me. I have also been provided the opportunity to ask questions of Hospital staff concerning the Inpatient Election Information Sheet to assist with my understanding. A hospital employee has not directed me to a particular decision. I understand that I can only alter my election in the event of unforeseen circumstances. In accordance with the Department of Health Privacy Policy, I authorise disclosure of information from my clinical records necessary for my continuing care and if applicable agree that a copy of this election form may be released to my private health fund. I understand that without this authorisation, my health fund may refuse to provide benefits. Patient Signature: _____ Date: ____/____/____ <b>To be completed if election is made and signed on behalf of the patient:</b> Legally Authorised Representative Signature: _____ Date: ____/____/____ Name of legally authorised representative: _____ Relationship to patient: _____ Phone Number (H) _____ (W) _____		
<b>Witness to Election</b>		
I certify that this patient / legally authorised representative has received the Inpatient Election Information Sheet. I certify that I witnessed the patient / legally authorised representative make the above election. Health Employee Signature: _____ Date: ____/____/____ <b>To be completed if an interpreter is used:</b> I have translated this election form and the Inpatient Election Information Sheet to the patient's native language and am satisfied that the patient understands the contents of these documents. Interpreter Signature: _____ Date: ____/____/____ Office use only <input type="checkbox"/> HC21 <input type="checkbox"/> Medicare Eligibility Checked <input type="checkbox"/> Simplified Billing Form <input type="checkbox"/> S/R Request Checked Classification _____ Changed from _____		

BINDING MARGIN - NO WRITING

FILE IN CLINICAL RECORD

 Original copy - Medical Record  
 Yellow - Finance

ID 630781 Jul 11

PRIVATELY INSURED/PUBLIC ELECTION

RPAH MR5H CRGH MR9/6 TCH MR1a BAL MR00

## Appendix 7: Focus group chief executive approval



Health  
Sydney  
Local Health District

memo

Chief Executive

TO Jason Cheng, A/General Manager, Croydon, Marrickville and Redfern Health Centres

FROM Dr Teresa Anderson, Chief Executive

CC

SUBJECT Doctorate Business Administration – Thesis

Dear Jason

Thank you for the opportunity to review your draft thesis on patients' decision about utilisation of private health insurance: Their motivation and its impact, and in particular what strategies had been successful in encouraging patients to use Private Health Insurance. Your research provided some useful insights into what future methods could be use to motivate patients in using their PHI.

I note that some of your findings and recommendations from your research might be applicable to other hospitals including those within the Sydney Local Health District (SLHD).

As such, it would be appreciated if you could organise a focus group consisting of General Managers and Revenue Managers from within the SLHD hospitals to discuss and review your findings and recommendations.

I would also like to attend the meeting. Please liaise with Ms Nerida Bransby, Executive Assistant to the Chief Executive on 9515 9641 to organise a mutually convenient time.

Should you wish to discuss this matter further in the interim please do not hesitate to contact me.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Teresa Anderson', with a long horizontal line extending to the left.

Dr Teresa Anderson

Date: 2-4-13

---

## **Appendix 8: Focus group briefing information for participants**

### **Focus group briefing:**

#### **Patients' decision about utilisation of private health insurance: Their motivation and its impact**

---

This research consisted of a number of sub-projects that aimed to understand a range of issues relating to private health insurance (PHI) utilisation in a NSW public hospital (Canterbury Hospital). There is the perception that some patients with PHI choose not to use it, and the rationale behind why patients choose to use or not to use PHI in public hospitals is surveyed.

The research identified a few main reasons as to why patients choose to use their PHI for public hospital admission

- Possibility to be admitted to a single room
- Being able to choose their own preferred doctor
- To help the hospital and the community
- Benefits that come with using PHI \* (various benefits)

The results have also identified several main reasons as to why patients have chosen not to use their PHI:

- Did not know they could use their PHI for their public hospital stay
- Were worried that their health insurance premiums may go up if they used their PHI
- Fear of out-of-pocket expenses.


In the second part of this research thesis, a financial model was developed to aid the analysis of the cost and revenue impact of encouraging patients to use PHI. It has been found that during the 2011/12 financial year at Canterbury Hospital, approximately \$3 million revenue was raised with a cost of roughly \$520,000. The return on investment (ROI) was approximately 5.59, indicating an excellent return versus cost.

#### **Recommendations for discussion:**

1. The findings of this research should be presented to all hospital executive and revenue teams.

- 
2. Changes in PHI revenue should be monitored. There may be a plateau effect for the intervention. If so, a more intensive (but likely less cost-beneficial) range of methods may need to be used, which may convert even more patients.
  3. Patient information should emphasise the top reasons as to why patients use their PHI, and neutralise the top reasons as to why others do not use their PHI.
  4. Discuss any potential barriers to the recommendations

## Appendix 9: Focus group briefing consent forms

 <p><b>Health</b> Sydney Local Health District</p>	<p style="text-align: center;">1</p>
<b>AUDIOVISUAL CONSENT FORM</b>	
<p>I, <u>PETER SANDBURY</u></p> <p>of _____ (ADDRESS) <u>DARLING POINT 2022</u></p> <p>hereby consent to myself being audio recorded:</p> <p style="text-align: center;">(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)</p> <p>I agree to the recordings being taken and used for: (tick whichever is applicable)</p> <p><input type="checkbox"/> TREATMENT</p> <p><input type="checkbox"/> CLINICAL PRESENTATIONS / MEETINGS</p> <p><input type="checkbox"/> QUALITY ASSURANCE</p> <p><input type="checkbox"/> TEACHING / TRAINING</p> <p><input type="checkbox"/> CLINICAL AUDIT</p> <p><input checked="" type="checkbox"/> RESEARCH / PUBLICATION JOURNALS</p> <p>as explained to me by:</p> <p style="text-align: center;">(SIGNATURE)</p> <p style="text-align: center;"><u>JASON CHENG</u></p> <p>(DESIGNATION/POSITION) <u>ALGM, Croydon, Marrickville &amp; Redfern Health Centres</u> (PHONE NUMBER) <u>9378 1100</u></p> <p>I understand that these recordings will only be used for the purpose described above and that identifying information about me / my _____ (RELATIONSHIP) will remain confidential.</p> <p>I understand that I may withdraw my consent, in writing, at any time in the future.</p> <p>SIGNATURE: <u>[Signature]</u> (DATE) <u>6.5.13</u></p> <p style="text-align: center;">To be used with policy SSW_GL2008_001 Management of Images and Audiovisual Records of Patients</p>	





Health  
Sydney  
Local Health District

## AUDIOVISUAL CONSENT FORM

I, Kate Benson

of

(ADDRESS)

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- ☐ CLINICAL PRESENTATIONS / MEETINGS
- ☐ QUALITY ASSURANCE
- ☐ TEACHING / TRAINING
- ☐ CLINICAL AUDIT
- ☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

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I understand that these recordings will only be used for the purpose described above and that identifying information about me / my

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I understand that I may withdraw my consent, in writing, at any time in the future.

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(DATE)

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## AUDIOVISUAL CONSENT FORM

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of A PAT (ADDRESS) MILBENDEN RD CAMPBELLTOWN

hereby consent to myself being audio recorded:

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I agree to the recordings being taken and used for: (tick whichever is applicable)

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[ ] CLINICAL PRESENTATIONS / MEETINGS  
[ ] QUALITY ASSURANCE  
[ ] TEACHING / TRAINING  
[ ] CLINICAL AUDIT  
[X] RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

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SIGNATURE:

ouille

6/1/13  
(DATE)

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Local Health District

## AUDIOVISUAL CONSENT FORM

I, TIM SINCLAIR  
of CONCORD HOSP. (ADDRESS)

hereby consent to myself being audio recorded:

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☐ CLINICAL PRESENTATIONS / MEETINGS  
☐ QUALITY ASSURANCE  
☐ TEACHING / TRAINING  
☐ CLINICAL AUDIT  
☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

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I understand that these recordings will only be used for the purpose described  
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will remain confidential. (RELATIONSHIP)

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[Signature]

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(DATE)

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## AUDIOVISUAL CONSENT FORM

I, Patricia Garrett

of L9, KSV (ADDRESS)

hereby consent to myself being audio recorded;

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

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[ ] CLINICAL PRESENTATIONS / MEETINGS  
[ ] QUALITY ASSURANCE  
[ ] TEACHING / TRAINING  
[ ] CLINICAL AUDIT  
[X] RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described above and that identifying information about me / my  
will remain confidential.

(RELATIONSHIP)

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

Patricia Garrett

(DATE)

6/5/2013

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## AUDIOVISUAL CONSENT FORM

I, Miranda Shaw

of LA, KAU (ADDRESS)

hereby consent to myself being audio recorded:

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

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- ☐ CLINICAL PRESENTATIONS / MEETINGS
- ☐ QUALITY ASSURANCE
- ☐ TEACHING / TRAINING
- ☐ CLINICAL AUDIT
- ☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described above and that identifying information about me / my

(RELATIONSHIP) Comments

will remain confidential.

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

[Signature]

6/5/2013

(DATE)

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Local Health District

## AUDIOVISUAL CONSENT FORM

I, Jason Anderson

of SLHD (ADDRESS)

hereby consent to myself being audio recorded:

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

- [ ] TREATMENT  
[ ] CLINICAL PRESENTATIONS / MEETINGS  
[ ] QUALITY ASSURANCE  
[ ] TEACHING / TRAINING  
[ ] CLINICAL AUDIT  
[X] RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described above and that identifying information about me / my (RELATIONSHIP) will remain confidential.

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

Jason Anderson

6 - 5/11/13

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## AUDIOVISUAL CONSENT FORM

I, HANNAH BARRINGTON

of SLHD

(ADDRESS)

hereby consent to myself being audio recorded:

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I agree to the recordings being taken and used for: (tick whichever is applicable)

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- ☐ CLINICAL PRESENTATIONS / MEETINGS
- ☐ QUALITY ASSURANCE
- ☐ TEACHING / TRAINING
- ☐ CLINICAL AUDIT
- ☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described above and that identifying information about me / my

(RELATIONSHIP)

will remain confidential.

I understand that I may withdraw my consent, in writing, at any time in the future,

SIGNATURE:

Hannah Barrington

06/05/13

(DATE)

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Local Health District

## AUDIOVISUAL CONSENT FORM

I, Claire Blizard

of SLHD Executive

(ADDRESS)

hereby consent to myself being audio recorded:

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I agree to the recordings being taken and used for: (tick whichever is applicable)

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- ☐ CLINICAL PRESENTATIONS / MEETINGS
- ☐ QUALITY ASSURANCE
- ☒ TEACHING / TRAINING
- ☐ CLINICAL AUDIT
- ☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described

above and that identifying information about me / my

(RELATIONSHIP)

will remain confidential.

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

C Blizard

6/5/2002 (DATE)

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Sydney  
Local Health District

## AUDIOVISUAL CONSENT FORM

I, John O'Grady,

of 10 Ashmore Street (ADDRESS) Erskineville 2043

hereby consent to myself being audio recorded:

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

- ☐ TREATMENT  
☐ CLINICAL PRESENTATIONS / MEETINGS  
☐ QUALITY ASSURANCE  
☐ TEACHING / TRAINING  
☐ CLINICAL AUDIT  
☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described above and that identifying information about me / my  
will remain confidential.

(RELATIONSHIP)

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

John O'Grady

6/5/13  
(DATE)

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CONSENT FORM



Health  
Sydney  
Local Health District

## AUDIOVISUAL CONSENT FORM

I, Genevieve L Wallace

of Balmain Hospital (ADDRESS) Booth St, Balmain.

hereby consent to myself being audio recorded:

Level 11 - Board Room.  
KLV.  
Missenden RD.

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

- [ ] TREATMENT  
[ ] CLINICAL PRESENTATIONS / MEETINGS  
[ ] QUALITY ASSURANCE  
[ ] TEACHING / TRAINING  
[ ] CLINICAL AUDIT  
[X] RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described

above and that identifying information about me / my

(RELATIONSHIP)

will remain confidential.

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

G Wallace

(DATE) 6/5/13

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CONSENT FORM



Health  
Sydney  
Local Health District

## AUDIOVISUAL CONSENT FORM

I, LISA PARCSI

of \_\_\_\_\_  
(ADDRESS)

hereby consent to myself being audio recorded:

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

- ☐ TREATMENT  
☐ CLINICAL PRESENTATIONS / MEETINGS  
☐ QUALITY ASSURANCE  
☐ TEACHING / TRAINING  
☐ CLINICAL AUDIT  
☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

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(RELATIONSHIP)

will remain confidential.

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

[Signature]

(DATE)

6.5.13

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CONSENT FORM



Health  
Sydney  
Local Health District

## AUDIOVISUAL CONSENT FORM

I, Ann Kelly

of Canberrra Hospital (ADDRESS)

hereby consent to myself being audio recorded:

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

- ☐ TREATMENT
- ☐ CLINICAL PRESENTATIONS / MEETINGS
- ☐ QUALITY ASSURANCE
- ☐ TEACHING / TRAINING
- ☐ CLINICAL AUDIT
- ☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described above and that identifying information about me / my (RELATIONSHIP) will remain confidential.

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

Ann Kelly

6-5-2013 (DATE)

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CONSENT FORM



Health  
Sydney  
Local Health District

## AUDIOVISUAL CONSENT FORM

I, Karen Becker

of 24 Liverpool Rd, Croydon, (ADDRESS) NSW

hereby consent to myself being audio recorded:

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

- [ ] TREATMENT  
[ ] CLINICAL PRESENTATIONS / MEETINGS  
[ ] QUALITY ASSURANCE  
[ ] TEACHING / TRAINING  
[ ] CLINICAL AUDIT  
[X] RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

I understand that these recordings will only be used for the purpose described above and that identifying information about me / my (RELATIONSHIP) will remain confidential.

I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

[Signature]

6/5/13 (DATE)

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Health  
Sydney  
Local Health District

## AUDIOVISUAL CONSENT FORM

I, LAVENA RAMDUTT

of 12/176-180 SAUSSEY RD (ADDRESS) CAMPBELLTOWN NSW 2050

hereby consent to myself being audio recorded:

(NAME OF HOSPITAL and DEPARTMENT or CLINICAL SERVICE)

I agree to the recordings being taken and used for: (tick whichever is applicable)

- ☐ TREATMENT  
☐ CLINICAL PRESENTATIONS / MEETINGS  
☐ QUALITY ASSURANCE  
☐ TEACHING / TRAINING  
☐ CLINICAL AUDIT  
☒ RESEARCH / PUBLICATION JOURNALS

as explained to me by:

(SIGNATURE)

JASON CHENG

(DESIGNATION/POSITION)

ALGM, Croydon, Marrickville & Redfern Health Centres

(PHONE NUMBER)

9378 1100

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I understand that I may withdraw my consent, in writing, at any time in the future.

SIGNATURE:

[Signature]

6 May 2013

(DATE)

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